ATTACHMENT C

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT AND REFERRING ORGANIZATION (Sign each entry)
9/6/05 0930	S= complains of itchy rashes on both arms & chest, as of last "several years". Reports been exposed to something while at work on Amtrak. Claims the medication given 1 month ago "don't help". O= temperature, T= 98.0°F; BP= 100/70 RR 18/m, RRR- + multiple papules lining on the arms, back & abdomen chest, not infected A= dermatitis/dry skin. P= referred to dermatologist - prescribed on prop flex cort & benadryl elixer tsp. - Teladerm shampoo, Hydrocortisone cream + Vit A+D oint - Nyst
	E. Panaguiton Mid-Level Practitioner FCC Petersburg, Virginia
	spoke call note reviewed 9/7/05 Dr. J. Allen Clinical Director FCC Petersburg
11/16/05 1015	Dermatology Clinic: pityrosporum folliculitis - a Grover's dermatitis Biopsy taken. RTC 1 month
	K. L. Laybourn, MD FCC Petersburg, Virginia 11-17-05
	A. Zayas, MLP Mid-Level Practitioner FCC Petersburg, Virginia
	Vincent Sansone, Pharm.D Counseling Provided
1/18/06 1320	Dermatology Clinic 1) Doxycycline 100 mg P.O. 2x daily x 1 month 2) F/u 1 month — ran
	Richard S. Forth, ARNP
	STANDARD FORM 600 (REV. 6-97) BACK
	K. L. Laybourn, MD FCC Petersburg, Virginia 1-18-06

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
6/1/05 1105	Ortho Clinic ① Clenched fist Allowed B/L wrists. ② F/U 2 months — Clearance RD KLL 6/2/05 K. L. Laybourn, MD FCC Petersburg, Virginia
8/9/05 1030	S: pt. c/o skin rash on arms & Trunk. Pt. has HO skin problems due to occupational work at Pet Milk Co. Pt claimed rash on arms. Ref 11/9/67 pg 269 T-98.2 Skin: Small typical papular bumps with whitish/yellowish material in cavity of some lesions. Pruritic skin. No excoriations are noted A. c/o follows: P. ① Septra DS 1 Tab po BID with lots of water x 14 days ② Pt told to drink a lot of fluids due to risk of stones. ③ F/u in 2 weeks thru Src A. Zayas, MLP FCC Petersburg-Low
8/17/05 1515	**Orthopedic Clinic** F/u PRN KLL K. L. Laybourn, MD FCC Petersburg, Virginia

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
Hill, K. 17110-016		

Health Services Unit
FCC Petersburg, Virginia

NSN 7540-00-634-4176 600-108

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2/10/05 1300	Admin Note Injury report done and X-ray of Wrist done [illegible]
3/10/05 0800 hrs	ADM-Early Orthopedic Consult via Phone based on X-rays Reading [illegible] PA-C
4/3/05 1130	S) 42 yr old male c/o rash on right side x 2 yrs. States rash first occurred after cutting tar board at FCI McLean while working in Unicor. Reports associated Symptoms of extreme itching.
BP 144/79	
P 69	
Temp 97.9	
	O) Alert & oriented x3. NAD. Stable gait. Skin c hyperpigmented rash on right flank area 8cm x 5cm. ϕ Scaling
4/5/05	A) Dermatitis
	P) 1) Triamcinolone cream - Apply sparingly 2x daily x 15 days (IRF). 2) Ketoconazole Shampoo - use daily during showers. 3) Consult for R/u dermatology evaluation Submitted. 4) R/u PRN
	[illegible]

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

17110-016

Hill, Kenny

HEALTH SERVICES UNIT-LOW
FCC PETERSBURG, VA

RECORDS MAINTAINED AT: ▶

R. Forth, PHS
Mid-Level Practitioner

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 6-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8-27-04	RECEIVED AT FCC PETERSBURG LOW, VIRGINIA
1405	Intake screening completed
	Present Medical Compliants (Yes) No
	If yes specify pain
	Place in: NA Chronic care clinic: NA
	PPD status: 6/10/04 PPD+ If positive, date of last chest X-ray:
	Medications Allergies: Yes (No)
	If yes specify NA
	Current Medications: ϕ
	If yes, specify medications issued or prescribed:
	N/A
	Sick call and pill line procedures explained: (Yes) No
	Have you have thoughts of harming yourself Yes (No)
	Referral to pschycology Yes (No)
	Have you tested positive for HIV? Yes (No)
	Do you have Hepatitis B? Yes (No)
	Have you come in contact with anyone with hepatitis B? Yes (No)
	Evidence of scabies or lice? Yes (No)
	Do you need information on a living will? Yes (No)
	Do you need information on advance directives? Yes (No)

V. Pegram RN

V. Pegram, R.N.
FCC Petersburg-LOW

SPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED BY
Petersburg Low, Virginia			
NSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

ENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. JOSEPH M. PAVARDO PHYSICIAN ASSISTANT

Hill, Kenney
17110-016

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

Health Services Unit-Low
FCC Petersburg, Virginia

PET

SF_600 (Face)

7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8/25/04 1800	Medical intake screening at FCC Petersburg Medium
	History of medication allergies: NO YES
	History of suicidal ideation: NO YES
	Referred to Psychology: NO YES
	Lice/Scabies inspection completed: YES
	History of infectious disease: TB, HIV or Hepatitis: NO Yes
	History of contact with a HBV person: NO YES
	PPD given: NO YES 6/10/04
	Labs requested: NONE CBC RPR UA
	Patient with living will: NO YES
	Do you need information on Advanced Directives: NO YES
	Sick-call, Pill-line and Callout procedures explained: NO YES
	Skin Examination: Normal / Abnormal Describe-
	Chronic care clinic referrals:
	Current medical complaints:
	Current medications:

A. Yirdaw, P.A.
FCI Petersburg, VA

PATIENT'S IDENTIFICATION (Use this space for mechanical Imprint)

RECORDS MAINTAINED AT: FCC PETERSBURG-MEDIUM

HILL
KENNY 17110-016
B/M/O/07-17-1962
HT/601 WT/226 HR/BK EY/BN
CUSTODY/IN

/GRADE

E OF BIRTH

(Rev. 5-84)
and ICMR
FIRMR (41 CFR) 201-45.505

BP-S659.60 **MEDICAL SUMMARY FEDERAL PRISONER/ALIEN I. .RANSIT** CDFRM
MAY 99
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TB Clearance Yes ✓ No __
1. PPD Completed: 6-10-04 Date
Results: 0x0 mm
2. CXR Completed: ____ Date
Results: ____
3. Health Authority
Clearance: OK
Sign ____ Date 8/18/04

Note:
Dates listed above must be within one year of this transfer.

Name	Prisoner/Alien Reg.#	D.O.B.
Hill, Kenneth	19110-016	2/27/62
Departed From	**Date Departed**	
McKean	8/20/04	
Destination	**Reason for Transfer**	
Pet	non-medical	
Dist. Name	**Dist.#**	**Date in Custody**
		__/__/__

Current Medical Problems
1. S/P CS w. Obj
2. Allergies
3. ____
4. ____
5. ____
6. ____

Medication	Dose	Route	Instructions For Use (Include proper time for administering)	Stop
			Medication Required For Care En Route	
			None	
08-25-04				
OK For Transfer FDC Philadelphia Meds: Yes ___ No ✓			A. Martinez Health Service Administrator FDC Philadelphia	

Additional Comments - Blood and Body Fluid Precautions

Special Needs Affecting Transportation

Is prisoner medically able to travel by BUS, VAN or CAR?	✓ Yes __ No	If no, why not?
Is prisoner medically able to travel by airplane?	✓ Yes __ No	If no, why not?
Is prisoner medically able to stay overnight at another facility en route to destination?	✓ Yes __ No	If no, why not?
Is there any medical reason for restricting the length of time prisoner can be in travel status?	__ Yes ✓ No	If yes, state reason
Does prisoner require any medical equipment while in transport status?	__ Yes ✓ No	If yes, what equipment?

Sign and Print Name - Certifying Health Authority	Phone Number	Date Signed
D. Olson, MD Clinical Director		8/18/04

Record copy - Transporting Officer: Copy - Health Record (Top page Position one); Copy - Transferring Institution

This form may be replicated via WP) **SIMILAR TO(USM 553)** Replaces BP-S659 of Mar 99

USP Lewisburg
Inmate Received, this date 8/20/04
Medical History Reviewed
Evidence of lice
1450 Suicidal Thoughts
Recent Assault, Trauma or Abuse
Signs and Symptoms of Infect Dse
Allergies to Medications
Medications

Yes No
Yes No
Yes No
Yes No
Yes No
Yes No

Ivan Navarro, PA

O.K. For Transfer
8/23/04 USP Lewisburg
Medications Yes ____ No ✓

Ivan Navarro, PA

8/25/04 RECEIVED AT F.C.I. PETERSBURG, VA
1800 NOT FULLY EVALUATED
OK FOR TRANSFER.
No Meds

A. Yirga, P.A.
FCI Petersburg, VA

26 AUG 2004

08-26-04 0830
Chart Reviewed
Not fully evaluated
cleared for transfer

N. Osorio, MLP
FCI Petersburg, PEM

8/27/04 0705 FCC RETURN Received at Rec

JOSEPH M. PALARDO
PHYSICIAN ASSISTANT

8/22/04
1835

RECEIVED AT C PHILADELPHIA ON THIS DATE:

PAIN 0 1 2 3 4 5

SICK CALL REFERRAL FOR PAIN? YES (NO)

☒ NO MEDICATIONS REQUIRED ☐ MEDICATIONS REQUIRED (SEE BELOW)

☐ SICK CALL AND PILL LINES PROCEDURES EXPLAINED

INMATE VOICED UNDERSTANDING (YES) NO

R. Ritter, MLP
FDC Philadelphia

G. Reynolds, M.D.
FDC Philadelphia
08-24-04

FDC PHILADELPHIA	STATUS	DEPART/SERVICE	RECORDS
SPONSOR'S NAME	SSN, ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S (For typed or written entries, give: Name-		REGISTER NO.	WARD

Hall, Kenneth
17716-016
7/17/62

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (Rev. 1-84)
Prescribed by GSA/ICMR
FPMR (41 CFR) 201-9.202-1

BP-S659.60 **MEDICAL SUMMARY OF FEDERAL PRISONER/ALIEN IN TRANSIT** CDFRM
MAY 99

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TB Clearance Yes ✓ No __
1. PPD Completed: 6-10-04 Date
Results: 0x0 mm
2. CXR Completed: ____ Date
Results: ____
3. Health Authority
Clearance: IC
Sign ____ Date ____

Note:
Dates listed above must be within one year of this transfer.

Name	Prisoner/Alien Reg.#	D.O.B.
Hill, Kenneth	79110-016	2/27/62
Departed From	Date Departed	
[illegible]	8/20/04	
Destination	Reason for Transfer	
Pet	[illegible]	
Dist. Name	Dist.#	Date in Custody
		__/__/__

Current Medical Problems
1. [illegible] 4. ____
2. All [illegible] 5. ____
3. ____ 6. ____

Medication	Dose	Route	Instructions For Use (Include proper time for administering)	Stop
			Medication Required For Care En Route	

Additional Comments - Blood and Body Fluid Precautions

Special Needs Affecting Transportation

Is prisoner medically able to travel by BUS, VAN or CAR?	✓ Yes __ No	If no, why not?
Is prisoner medically able to travel by airplane?	✓ Yes __ No	If no, why not?
Is prisoner medically able to stay overnight at another facility en route to destination?	✓ Yes __ No	If no, why not?
Is there any medical reason for restricting the length of time prisoner can be in travel status?	__ Yes ✓ No	If yes, state reason
Does prisoner require any medical equipment while in transport status?	__ Yes ✓ No	If yes, what equipment?

Sign and Print Name - Certifying Health Authority	Phone Number	Date Signed
[illegible]		[illegible]

Record copy - Transporting Officer: Copy - Health Record (Top page Position one); Copy - Transferring Institution

This form may be replicated via WP) **SIMILAR TO(USM 553)** Replaces BP-S659 of Mar 99

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
6-3-04 0930hr	(S.) 41y/o AAO* c/o LLE (leg & Foot) swelling & Pain & paresthesia x3 wks.; Hx GSW-LLE @ knee. Denies Recent Injury (Note: New Boots 1 mos. RTC - 5/11 5/28/04 Visit Same c/o Reports - Chronic Pain c 4/10 LLE- Leg Calf - Paresthesia Plantar Foot & Lateral Planta. Denies issue c Lt. Hip & knee or Femur. (O.) CAO x3, NAD, Ambulatory, NL Gait, (+) Deficit. (LLE) FROM (active) - Hip, Knee, Ankle, Foot - (+) Edema/Swelling - (+) Warmth/color/appearance/Pulses/Otes = RLE - Length = RLE - Calf - NT, (-) red, (-) Mass - Ankle - Stable, (+) Pain - Foot - NT, c Hyperkeratinous diffuse Plantar - ↓ Pain/Touch Sense (VS) Rt. Foot Back - (-) deformity, NT, (-) SI. Leg. (A.) Callouses/Hyperkeratinosis; Boots (New), (-) Neurovascular. (P.) Educate/Counsel (+) Via Gentleman and Degen. Soak/Rest/Elevate LLE @ rest (+) Resize/Refit Boots RTC PRN, Understand & agree.

Robert E. Piotrowski, PA-C
FCI McKean

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

Hill, Kenny 17110 016

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
2-20-04 1200	ADMIN NOTE:
	1) Make arrangements for boot exchange (see 2-19-04). Im can receive a cleaned/"sterilized" pair of used BOP boots in exchange for his leaking boots. (NO NEW boots can be issued, per Laundry).
	2) IM cannot be NEW boots. Refuses boot exchange.
	Steven Labrozzi, PA-C Physician Assistant
	WANTS to BE SEEN. No appt. No call-out. No call via CO.
5/28/04 1215	S) C/o numbness in Lower L Leg x 2 weeks Ⓟ Hx GSW 1980s recurrent pain in this area since 1980s PAIN: throbbing +9/10 burning tingling
	NAD ... able to ambulate 3 accident disability
	O) M/S-SKIN-Neuro -GSW scars entry: superior (proximal L) Anterior Patella (L) exit: distal to (L) Popliteal space greatest pain at Popliteal space Full AROM Knee + Ankle
	-DTRs - Patellar equal bilaterally - Unable to elicit Achilles reflex in (L) ankle Full reflex at (R) ankle
	-PT claims ↓ sensation/anesthesias across entire lower L Leg, at plantar/dorsal foot + at toes 3, 4, 5.
	- No ATROPHY - PT pulses intact
	A) Anesthesias. Paresthesias } 2° GSW c PAIN
	P) 1. Indocin 25mg 1-2 po c food/milk TID. #42 Rx1
	2. PT ED: Nerve damage, Poor to No Tx options. Meds. } PT understands
	3. RTC prn
	Steven Labrozzi, PA-C Physician Assistant
	Reviewed By: V. Geza, PharmD

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
2-19-04 08/5	(S) C/o feet problems: C/o leaking boots. present boots x 2.5 yrs. WANTS NEW PAIR OF BOOTS
	C/o Calluses x "long time" PAIN: +8/10
	C/o pulled muscle in back p lifting heavy furniture in UNICOR yesterday. PAIN = "ache" +9/10
	(O) NAD SKIN: ⊕ hyperkeratotic regions of feet ⊕ xerosis ⊕ onychomycosis } feet
	M/S ⊕ Pain to palp of sacral bones, SI joints. ROM: flexion limited to 45° Pain also upon extension, twisting, lateral bending.
	(A) Calluses. LBP
	(P) 1. Motrin 800mg tpo c food/milk TID. #30 Rx1
	2. Salicylic Acid Plasters soak x5min. Apply sized plaster x48 hrs. Remove plaster + dead skin. Repeat #2 bandaid strips Rx5
	3. Pt refuses cell. Has supervision evidently will allow him to do only paperwork during time back is hurting.
	4. Referral to Mr. Montgomery RE: shoe problem.
	5 " to Commissary for muscle balm.
	6. Pt understands tx plan. RTC prn.
	Referred to commissary for OTC medications for refills. Reviewed By: V. Geza, PharmD

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

Hill, Kenneth 17110-016

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9/4/03	Excoriations.
0945 hr	(2.) LT. Foot Lateral Plantar Surface 1x 1.5 cm
Continued	hyperkeratinized lesion - c (++) Tender ϕ discharge ϕ Fluid ϕ Red.
	(1.) (2.) Dermatitis NO (NKA) allergy
	(2.) Callous / Corn
	(P.) Hydrocortisone Crm. 1% AAA BID #1 tube c Rfx.
	Benadryl 25mg Cap @ HS PO Q4-Q6H PRN #20 c Rfx.
	Salicylic Acid Aster Patch x 1 Box c Rfx. x1
	P.I. Educated & understands
	RTC - PRN
	(- Soak area x 5 min & DRY - Apply "sized" patch - Maintain x 48 hrs & Repeat - Continue repeat x 3 weeks)
	Robert E. Piotrowski, PA-C FCI McKean
	Reviewed By: V. Geza, PharmD
9-12-03	Inmate Rec'd 4 pgs. Medical Records J. Petruzzi 4 TS
1230	T. Petruzzi, HIT
10-31-03	S: c/o "itchy feet" x several months. Suspects the showers are causing rash.
0855	O: NAD. Feet c maceration - peeling interdigitally, b/l.
	A: T. pedis
	P: Mycelex Cream 2%, apply to AA bid Rx #1. PI education re: fungus.
	RTC prn. PI understands B Saylor, NP c
	Reviewed By: V. Geza, PharmD
	BONNIE SAYLOR, NP
7m 7m 9m	

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6-17-03 1035	S: Requests "respiratory exam." "Wants to be checked out & make sure he's okay." "Feeling light-headed lately and afraid of germs because unit is filthy." C/o "dryness in throat sometimes." Denies other S+S.
	O: NAD. Appears well. Temp: 99 BP: 135/78, P: 69, Or Sat: 96%
	Chest: CTA bil. PFM: 750 l/min
	A: Normal vitals
	P: Reassure I/M. Pt. education re: hand washing technique, ↑ fluids, RTC prn. I/M understands. B. Saylor NP-C
	BONNIE SAYLOR, NP FCI MCKEAN
	Reviewed by D. Olson, MD Date 6/27/03
8-11-03 1045	No show for S/C appointment. B. Saylor NP-C
9/4/03 0745hrs	(S.) 41 y/o AA ♂ c/o (1.) Rash Bilat. UE's & face/neck x3 mos — itchy, ↓ Pain ? Source Unknown ↓ Pain Hx. (2.) Lt. foot +6/10 Pain 2° Callous/Corn (O.) CAO x3, Ambulatory, NL. Gait, ↓ affect. (1.) Papular Non Vesicular Lesions Bilat. UE's @ Wrist Circumferential & Few Neck c & Face c ⊕

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
Hill, Kenneth	17110-016	

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4/14/03	(S) C/O HAs, nosebleeds, dry nostrils × 1 year.
0730	↳ "dizzy" temporal areas, b/lat "aching" +6/10 comes & goes. ↑ with/when IM goes to work. } IM denies sensory prodrome/aura
	Nosebleeds when nostrils are dry ... only occasionally.
	(O) NAD T = 97.7°F
	HEENT: ⊕ "pain" to palp f/m sinuses, but also "pain" when occiput, parietal, & maxillary areas are palpated.
	IM denies sensation of "pressure" when leaning forward (head ↓ below knees)
	Turbinates: +2.5/4 ⊕ erythema ⊕ evidence of recent epistaxis ⊕ striations (white colored) in left nostril (dry nasal mucosa)
	Oropharynx ∓ exudate ⊖ adenopathy.
	(A) Headaches
	Dry nasal mucosa
	(P) 1. N.S. (Saline) Nasal Spray 2 sprays both nostrils QID + prn #1 Rx×3
	2. Motrin 400 mg T po QID prn HAs #30 Rx×3
1/14/03	3. IM Ed: use of meds IM understands
	4. RTC prn.
	Violette Geza, PharmD. RPh Chief Pharmacist — Steven Labrozzi, PA-C Physician Assistant
4/21/03	Inmate Recd 12 pgs. Medical Records — T. Petruzzi, HIT
0830	

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

Hill, Ken

REGISTER NO. 17110 016

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
(S)	C/o rash in private area x 2-3 months
3/26/03	⊕ itching ⊕ burn ⊕ pain +5/10
1410	inm believes it's a jock itch. Hot rash while playing sports & from using BOP shower water.
	C/o athletes foot b/c "poor sanitation in BOP showers" x 3 months.
	⊕ itching ⊕ burning ⊕ pain +5/10.
	C/o rash on abdomen ⊕ itching
(O)	⊕ scaling erythematous lesions underneath scrotum & on innermost inguinal leaf.
	⊕ macular hyperpigmented 2 x 3 x 4 inch patches — one on RLQ, one on LLQ
	⊕ scaling lesions ⇔ toes.
(A)	- Dermatitis
	- Tinea Pedis
	- Tinea Cruris
(P)	1. Miconazole 2% Cream — Apply sparingly to cleansed & dried areas of groin, feet, & abdomen BID — #1 tx x 5
	2. Valisone 0.1% Cream — apply sparingly to cleansed & dried abdominal regions BID — #1 R x 2
	3. Inm understands tx plan. ED — re: use of meds hygiene alterations
	4. FU prn via / S/C.

S Labrozzi
Steven Labrozzi, PA-C
Physician Assistant

REVIEWED
3/27/03
H. BEAM, MD
FCI MCKEAN

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1/7/03 1055	S: Req. topical cream for athlete's feet + jock itch O: Thick white patches between toes. ∅ open areas. Hyperpigmented scaley areas noted in bil. Groin A: Athlete's feet Jock itch P: Mycelex cream #1 Apply to aa bid x 2R Pt educ. use of cream as directed. Skin Care discussed. RTC prn. Pt understands Grace Fairbanks PA G. Fairbanks Physician Assistant
1/7/03 Violette Geza, PharmD. RPh Chief Pharmacist	
1/30/03 0940	S: C/O rash in groin area and feet not relieved by medication. Requesting alternative tx. O: NAD. Groin: c hyperpigmented scaly lesions bil. feet: c mild vesicular peeling interdigitally. A: Jock itch, T. pedis P: Tolnaftate cream #1, apply to AA's bid RX2 pt. education: wash hands between administrations of AA's RTC prn. Pt understands BS Surya PA
1/30/03 Violette Geza, PharmD. RPh Chief Pharmacist	BONNIE SAYLOR, NP FCI MCKEAN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

Hill, Kenneth
17110-016

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9/13/02 0835	(S) c/o rash on neck & athletes foot x 1 wk. Hx of same. denies fever (O) NAD neck - no rash noted feet - fungus between toes both feet (A) 1) Athletes feet (P) 1) Mycelex crm. to feet BID #1WK 2) Educated on Rx + foot care verbalized understanding 3) F/U prn sick call J. GLENN, FNP FCI MCKEAN
9/13/02 N.V.G. Pharm'd V.Cora (Pharm'd)	
12/4/02 1115	Physical exam done Gracia Fairbanks, MLP

NSN 7540-00-634-4176

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8/28/02	(S) IM requests PE
1030	(O) T= 97.4°F BP= 116/72 sitting, LA SKIN: ⊖ lesions, rashes. IM has tattoos HEENT: sclera white conjunctiva - pink turbinates +3/4 (some edema) TMs pearly gray Oropharynx 3 exudate/erythema ⊖ adenopathy ⊖ palpable thyroid LUNGS: CTA Heart: RRR 3 m/g/r. S1 + S2 distinct Abd: soft. ⊖ guarding. BSNA x 4 quads ⊖ organomegaly GU: ⊖ hernias. testes: smooth Rectum: ⊖ hemorrhoids prostate: smooth M-S: Full ROM +5/5 strength throughout Feet: Ⓐ onychomycosis Eyesight: 20/15 Rt eye 20/30 Lft eye.
	(A) Essentially healthy 40 yo BM
	(P) 1) F/U at sick call for medical/dental problems, as they arise 2) Write cop-out to Optometrist if vision while reading is bothersome. 3) IM understood exam + recommendations.
	L Labrozzi PA-C Labrozzi
	Reviewed by D. Olson, MD Date: 8/28/02

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

Hill, Kenny

REGISTER NO. 17110-016 | WARD NO.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
8/8/02 0915	S: Cmt to c/o itchy rash on neck + (L) elbow O: Maculopapular erythem. scaley lesions on bil neck + (L) elbow c (+) evidence of itching noted. ø pustules. ø drg A: Dermatitis P: HC cream #1 Apply to aa bid x 1R Pt educ. Use as directed. Skin care discuss RTC prn. Pt understands Gracia Fairbanks PA Reviewed by D. Olson, MD Date: 8/9/02 GRACIA FAIRBANKS Physician Assistant
8/19/02 0930	S) c/o yeah itch x 1wk. denies pain O) NAD gen - mild papular/macular rash c mild erythema A) Yeah itch P) 1) Myelex crm. to aa BID #1R 2) Educated on Rx + skin care 3) F/U prn each cell Reviewed by D. Olson, MD Date: 8/19/02 J. Glenn PA J. GLENN, FNP FCI McKEAN

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
7/11/02 0930	(S) c/o rash on neck + arms/ elbows has athletes foot both feet denies pain (O) NAD neck, arms, elbows - dry area c fine papular rash c erythema feet + fungus noted between toe both feet (A) 1) Dermatitis 2) Athletes foot (P) 1) Hydrocortisone cream to areas on neck arms BID sparingly #1 NR 2) Mycelex cream to feet BID as directed #1 RX 3) Educated on Rx, foot care + F/U agents plan 4) F/U prn sick call J. GLENN, CRNP

J. Glenn CRNP

REVIEWED BY R. BEAM, MD 7/11/02 FT McKEAN

OSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVIC	RECORDS MAINTAINED AT
PONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

ATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)	REGISTER NO.	WARD NO.
Hill, Kenny	17110-016	

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3-26-02 1005	S: Requests circumcision. C/o "regular infections". C/o tight band of foreskin when hurts when pulled back.
	O: NAD. Penis c tightly banded foreskin c infection, discharge, erythema
	A: tight foreskin
	P: Consult c MD's pa: Ed. Pt. education re: skin care. RTC PRN. Pt. understand. B. Saylor NP
	BONNIE SAYLOR, NP FCI McKEAN
5-23-02 1116	S: C/o burning + itching between toes x 2 wks. Seeks relief.
	O: NAD Maceration + peeling between toes.
	A: T. pedis bil
	P: Mycelex #1 apply to AA's bid. Rx 2. Pt education re: skin care RTC PRN. Pt understands B. Saylor NP
	BONNIE SAYLOR, NP FCI McKEAN
	Reviewed by: D. Olson, MD Date 5/29/02
6-13-02 1045	S: C/o rash on L neck and elbow. Present x 1 week. Itches. Requests relief.
	O: NAD. L neck + elbow c quarter-sized dry macular lesions.
	A: dermatitis
	P: Hydrocortisone Cream #1, apply to AA's bid. Rx 1. Pt education re: skin care. RTC PRN. Pt. understands. B. Saylor NP
	BONNIE SAYLOR, NP FCI McKEAN
	Reviewed by D. Olson, MD Date 6/17/02

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/21/01 1245	S: Requesting top cream for jock itch + AF O: Defered A: Jock itch. Athletes foot P: Mycolog cream #1 Apply to aa bid x 2R Pt edu: Use as directed. Skin care, hand washing discussed. RTC prn. Pt understands Gracia Fairbanks PA Gracia Fairbanks, MLP Reviewed by D. Olson, MD Date: 8/22/01
1-22-02 0855	S: C/o falling x 2 days ago and pulling muscle in @ groin. Painful. Also c/o itching between toes. Weeks ty. [Pain in groin is "8 out of 10."] O: NAD. @ groin c inflammation, erythema or tenderness c palpation. FROM observed. ↓ Extremities: c maceration and peeling interdigital b/l. A: muscle strain; tinea pedis P: Motrin, 400 mg. 1 tab po q 8° c food #21, pk. Warm compresses to AA prn. Mycolog #1, apply to AA bid, Rx1. Pt education re: hygiene. RTC prn. Pt understands. B. Saylor, NP Bonnie Saylor, NP Reviewed by D. Olson, MD Date 1/22/02

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

Neil, Kenneth
17110-016

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8/3/01 0617	S: Need refill on the following O: bilateral A. foot interdigital, jock itch bilateral. A: A. foot / Jock itch. P: (1) Mycelex cream #1 use BID R & L (2) Keep area clean / dry (3) Follow up on SP. (4) Meds Today OK Gomez, MLP Reviewed by D. Olson, MD Date: 8/3/01
081301 0800	S: Requesting refill on antifungal for athletes foot O: Deferred A: Athletes feet P. Lotrafate Creme 1% #1 : 1 Refill per. G. Fairbanks. Cheryl Lundberg, RN Gracia Fairbanks, MLP Reviewed by D. Olson, MD Date: 8/14/01

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/6/01	Intake screening E.H.M. 38 y/o
1130	No Allergies. No suicidal ideations
	NKDA. NO meds.
	— hx of IVDA V.D. Hepatitis or T.B.
	NO change in medical status.
	J. Gomez, MLP
6/5/01	3 Tuberculin Readings
0750	0 " "
	A " "
	PPD read Skin Care Instructions RT Forearm
	Tolnaftate Appl TID x 1
	Patient Education: Dosage, Special Instructions — C. Dyer, R.Ph CNO
	W. Flatt, MLP
6/8/01	Pharmacy Note
1100	(See note 6/5/01) (1) Appl HC 1% Cream BID x 1 wk
	Patient Education: Dosage, Special Instructions — C. Dyer, R.Ph CNO
	D. Olson, MD Clinical Director

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.
17110-066	

Hill, Kenny

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

HOLDOVER

BP-S149.060 **MEDICAL RECORD OF FEDERAL PRISONER IN TRANSIT** CDFRM
JUL 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TB Clearance

PPD Completed: 6-28-00 (Date)
Results: 0 mm
Interpreted as: Negative (Positive or Negative)
CXR Completed: _____ (Date)
Results: _____

Note: Date(s) listed above must be within one year of this transfer.

Name: Hill, Kenny Reg. No. 17110-016
Departed From: USP Terre Haute Date Departed: 3/28/01
Destination: MCK (Name of Institution) Reason for Transfer: non medical
Special Instructions: Blood and Body Fluid Precautions
Med Allergies: NONE

Diagnoses: 1. NORMAL HEALTHY ♂ 4.
2. 5.
3. 6.

No inmate may be transferred to any BOP facility unless either PPD or CXR results are satisfactory for medical clearance.

MEDICATION FOR CARE ENROUTE

Medication	Dose	Route	Instructions for Use (Include proper time for administering)	Stop
NONE				
			Continue medications as directed until medically evaluated.	

Signature of Certifying Medical Staff Member: John W. Smith MA | Title: | Date Signed: 3-27-01

PROGRESS NOTES ENROUTE

Date	Time	Institution	Symptoms, Findings, Medications, Treatment, Order, Etc.

edication times at USPTH:

ily 0600
vice Daily 0700 & 1700
ree Times Daily 0700 & 1000 & 1700
our Times Daily 0700 & 1000 & 1700 & 2100
edtime 2100

less Specified by Drs. Order

Attach SF-600 if additional space is required.

Record copy - Transporting Officer; Copy - Health Record (Top page, Position one); Copy - Transferring institution

(This form may be replicated via WP)

This form replaces BP-149.060 and BP-S149.060 dtd Nov 1994

Printed on Recycled Paper

Federal Transfer Center
Oklahoma City, OK MAR 28 2001
Date _____
Medication: ____ Yes ____ No
Hot Meds: ____ Yes ____ No
Meds Issued: ____ Yes ____ No
Lice Seen: ____ Yes ____ No

Signature & Stamp
Todd Genzer
Clinical Nurse
FTC, Oklahoma City, OK

Food or Drug Allergies:
NKA; Allergies: _____

Current Medical Status:
No Complaints; Complaint of _____

TB Signs and Symptom (s): NONE ;
cough, hemoptysis, night sweats, wt. loss

Medication Times:
Once Daily = 6:00 AM
2x Daily = 6:00 AM & 3:30 PM
3x Daily = 6.00 AM, 11:30 AM, 3:30 PM
4x Daily = 6:00 AM, 11:30 AM, 3:30 PM, 8:30 PM
Cleared Pharmacy for Transfer.
FTC, Oklahoma City, OK

MAR 30 2001

USP Lewisburg
Inmate Received, this date 02 APR 2001

Medical History Reviewed	Yes	No
Evidence of lice	Yes	No
Suicidal Thoughts	Yes	No
Recent Assault, Trauma or Abuse	Yes	No
Signs and Symptoms of Infect Dse	Yes	No
Allergies to Medications	Yes	No
Medications	Yes	No

M. A. Peoria
Mark Peoria, PA-C

O.K. For Transfer
USP Lewisburg
4/6/01 Medications Yes

Ivan Navarro, P.A.

FCI/FPC McKean
Inmate Received this date 4/6/01
Medical History (BP-360) Reviewed yes
Evidence Body Lice: Yes/No
Medications: Yes/No - Given _____

J. Gomez, MLP

HOLDOVER

NSN 7540-00-634-4176

600-10

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
1120 01-12-00	Adm. note: Intake exam completed — Yusim PA-C
1229-00 1450	C. Scaly patch foot & dry scaly thickened nails on toes & scaly lesions abs scalp & several raised reddish, keratotic lesions on scalp. Prescribed Nizoral shampoo BID to scalp, Keratolytic TID to feet & scalp, Lotrimin cream TID to feet. Pt voices understanding — J. Williams, PA-C

A. Instructions, PA

PATIENT'S IDENTIFICATION *(Use this space for Mechanical print)*

HILL,KENNETH 17110-016

USP TERRE HAUTE, IN

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDI...

MEDICAL SUMMARY OF FEDERAL PRISONER/ ALIEN IN TRANSIT

U.S. Department of Justice

2C

TB Clearance ☒ Yes ☐ No

1) PPD Completed: 6/28/00 Date

Results: 0 mm

2) CXR Completed: _____ Date

3) Health Authority Clearance: [signature] 7/3/00

Sign Date

Note: Dates listed above must be within one year of this transfer.

I. PRISONER/ALIEN

Name: HILL, KENNETH | Prisoner/Alien Reg. #: 17110-016 | D.O.B:

Departed From: USM LEW | Date Departed: 7/3/00

Destination: | Reason for Transfer:

Dist. Name: | Dist. # | Date in Custody:

II. Current Medical Problems

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

			Medication Required For Care En Route	
Medication	**Dose**	**Route**	**Instructions For Use** (Include proper time for Administering)	**Stop**

Additional Comments:

III. SPECIAL NEEDS AFFECTING TRANSPORTATION

Is prisoner medically able to travel by BUS, VAN or CAR? ☐ Yes ☐ No If no, Why not?

Is prisoner medically able to travel by airplane? ☐ Yes ☐ No If no, Why not?

Is prisoner medically able to stay overnight at another facility en route to destination? ☐ Yes ☐ No If no, Why not?

Is there any medical reason for restricting the length of time prisoner can be in travel status? ☐ Yes ☐ No If yes, state reason:

Does prisoner require any medical equipment while in transport status? ☐ Yes ☐ No If yes, What equipment?

Sign & Print Name- Certifying Health Authority: | Phone Number: | Date Signed:

Original–Upon Transfer

Form USM-553 (Est 6/98)

Federal Transfer Center
Oklahoma City, OK
Date JUL 0 3 2000

Medication: ____ Yes ____ No
Hot Meds: ____ Yes ____ No
Meds Issued: ____ Yes ____ No
Lice Seen: ____ Yes ____ No

Signature & Stamp

Todd Genzer
Clinical Nurse
FTC, Oklahoma City, OK

CXR ORDER DATE JUL 0 3 2000

FOLLOW UP PPD, IF INDICATED AT FINAL DESTINATION

SIGNATURE AND STAMP

Brian Cronenwett, LT.
Registered Nurse
Federal Transfer Center, OKC, OK

Medication Times
Once Daily = 6:00 AM
2x Daily = 6:00 AM & 3:30 PM
3x Daily = 6:00 AM, 11:30 AM, 3:30 PM
4x Daily = 6:00 AM, 11:30 AM, 3:30 PM, 8:30 PM
Cleared Pharmacy for Transfer
FTC, Oklahoma City, OK

JUL 05 2000

7-6-00
1030

U.S. PENITENTIARY
TERRE HAUTE
MEDICAL SERVICES

S.F. 71 AND S.F. 93 REVIEWED-ORIGINATED
NO MAJOR MEDICAL COMPLAINTS
VOICED. WILL CONTINUE ABOVE
RECOMMENDATIONS.

D Farmer RN

Hill, Ken
17110-016

PE

U.S. PENITENTARY TERRE HAUTE, IN. 47808

URINALYSIS

SPECIMEN/LAB RPT NO

URGENCY: ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☒ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☒ ROUTINE ☐ OTHER (Specify)

PATIENTS MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE: Lawson

REPORTED BY: MD TECH

DATE: 7/21/03

LAB. ID NO.

REMARKS

1130 AM

TEST(S) | SPECIMEN TAKEN DATE 7/4 TIME 930 A.M. P.M. | RESULTS | REQUESTED (X)

ROUTINE: Yellow, Hazy, Trace, 1, 1, 1, 1, 1, 1, 1, 1, 55, 1035

MICROSCOPIC: WBC, RBC, EPITH CELLS; CASTS: WBC, RBC, HYALINE, GRANULAR; BACTERIA, CRYSTALS, MUCUS, NITRITE, BENCE-JONES PROTEIN, HEMOSIDERIN, HCG

Clinical Director

URINALYSIS 560-107

Standard Form 550 (Rev. 4-77) General Services Administration Committee on Medical Records FIRMR (41 CFR) 201-45.505

Hill, Ken
17110-016

PE

U.S. PENITENTARY TERRE HAUTE, IN. 47808

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY: ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☒ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE: Lawson

REPORTED BY: MD TECH

DATE: 7/24/03

LAB. ID NO.

REMARKS

230pm

TEST(S) | SPECIMEN TAKEN TIME 900 A.M. P.M. | REQUESTED (X)

RBC COUNT, HEMOGLOBIN, HEMATOCRIT, MCV, MCH, MCHC, WBC COUNT

WBC DIFF AND BLOOD CELL MORPH.: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC

SED. RATE, PLATELET COUNT, RETICULOCYTE COUNT, CLOTTING TIME, BLEEDING TIME, PT CONTROL, PT PATIENT, PTT CONTROL, PTT PATIENT, ACTIVITY, SICKLING, E PREP

Clinical Director

TOLOGY 549-107

RM 549 (Rev. 7-78) BY GSA/ICMR FRI 201-45.505

SPECIMEN/LAB RPT NO

Hill
17110-016

a/o

09-02-04 06:55

CLARITY: _____
COLOR: YELLOW

MULTISTIX 10 SG

GLU NEGATIVE
BIL NEGATIVE
KET NEGATIVE
SG >=1.030
BLO NEGATIVE
pH 5.0
PRO NEGATIVE
URO 0.2 E.U./dL
NIT NEGATIVE
LEU NEGATIVE

PATIENTS MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

REMARKS

Dr. K. Laybourn, M.D.
Medical Director

TEST(S) | SPECIMEN TAKEN: DATE, TIME, A.M., P.M. | REQUESTED (X) | ROUTINE RESULTS | COLOR | SPECIFIC GRAVITY | UROBILINOGEN | OCCULT BLOOD | BILE | KETONES | GLUCOSE | PROTEIN | pH | MICROSCOPICS | WBC | RBC | EPITH CELLS | CASTS: WBC, RBC, HYALINE, GRANULAR | BACT | CRYS | MUC | MISC | BLOOD PRESS | HT | WT

Standard General Services Committee on Medical Records FIRMR (41 CFR) 201-45.303

Hill, Ken
17110-016

PE

SPECIMEN/LAB. RPT. NO.

SEROLOGY

URGENCY: ☑ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☑ AMB
OUTPATIENT: ☐ NP ☐ DOM

SPECIMEN SOURCE: ☑ BLOOD ☐ OTHER (Specify)

PATIENTS MED. RECORD

U.S. PENITENTARY TERRE HAUTE, IN. 47808

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE: Lawson

REPORTED BY: MD / TECH

DATE: 8/1/05

LAB. ID. NO.

REMARKS

EXPECTED RESULTS: NON REACTIVE

730Am

551-107

TEST(S) | SPECIMEN TAKEN: DATE 7/14, TIME 2 P.M., A.M., P.M. | REQUESTED (X) | RESULTS: NR | INF. MONO QUAL. | INF. MONO QUANT. | RPR: AUTO / CARD | VDRL QUAL. | VDRL QUANT. | FTA-ABS | TPHA | RHEUMATOID FACTOR | ANTI-NUCLEAR FACTOR (ANF) | COLD AGG. | KAHN | VENEREAL DISEASE RESEARCH LAB. (VDRL) | COMPLEMENT FIXATION | FEBRILE AGG | COMP. FIX. | HAI | THYROGLOBULIN ANTIBODY | THYROID MICROSOMAL ANTIBODY

G. Lawson Clinical Director MD

SEROLOGY

STANDARD FORM 551 (Rev. 6-77) General Services Administration and Interagency Committee on Medical Record FIRMR (41 CFR) 201-45.305

FEDERAL MEDICAL CENTER CLINICAL LABORATORY

OLD HIGHWAY 75
BUTNER, NC 27509
(919) 575-3900

Laboratory Supervisor:
Bob Latina

Printed: 09/08/2004 @ 15:18

FINAL REPORT
*** SENSITIVE - LIMITED OFFICIAL USE ***

Name: HILL, KENNY Lab #: 020197 ID: 17110-016

Test	Result	Flag	Reference Range/Units
HEMATOLOGY			
CBC w/DIFF			
WBC	6.5		4.0 - 11.0 10^3/uL
RBC	4.96		4.50 - 5.50 10^6/uL
Hgb	14.0		14.0 - 17.0 g/dL
Hematocrit	43.3		42.0 - 50.0 %
MCV	87.4		80.0 - 100.0 fL
MCH	28.3		25.4 - 34.6 pg
MCHC	32.4		31.0 - 37.0 g/dL
RDW	12.9		11.0 - 15.0 %
Platelets	268		125 - 400 10^3/uL
MPV	8.6		7.0 11.0 fL
Neutrophils %	67.6		40.0 - 75.0 %
Lymphocytes %	25.1		15.0 - 45.0 %
Monocytes %	**5.9**	LO	6.0 - 15.0 %
Eosinophils %	1.2		0.0 - 7.0 %
Basophils %	0.2		0.0 - 2.0 %
Neutrophils #	4.4		1.5 - 7.1 10^3/uL
Lymphocytes #	1.6		0.9 - 3.3 10^3/uL
Monocytes #	0.4		0.3 - 1.1 10^3/uL
Eosinophils #	0.1		0.0 - 0.7 10^3/uL
Basophils #	0.0		0.0 - 0.2 10^3/uL
SEROLOGY			
RPR	Nonreactive		Nonreactive

9-9-04 JN

Dr. K. Laybourn, M.D.
Medical Officer

9-10-04

Legend
High = HI Low = LO Critical = CR Abnormal = AB

ID: 17110-016
Name: HILL, KENNY
Ordered By: LAYBOURN
Collected: 09/01/04@ 09:35

DOB: 07/17/1962 Age: 42yr Sex: M
Lab Accn: 020197
Reviewed_____
Location: Petersburg Low

BP-S622.060 **RADIOLOGIC CONSULTATION REQUEST/REPORT** CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Patient Identification Name, Register Number, Institution	Age	Sex	EXAMINATION REQUESTED
Hill, Kenneth 17110-016 FCC - Petersburg (LOW)	42	M	Wrist - 3v min. (73110)
	Pregnant ___Yes X No		
	Requested by: Katherine A. Laybourn, M.D.		Date Requested: 6-3-05

Specific reason(s) for request (Complaints and findings)

Evaluate scaphoid ligament dissociation.

Date of examination	Date of Report	Date of Transcription	Film #
6-3-05	8-6-05		

Radiologic Report

Exam: Both Wrists - clenched fist view.

Conclusion: Diastatic scapholunate joint bilaterally, right greater than left.

Findings: There is no acute fracture or significant bony abnormality. There is diastasis of the scapholunate joint space bilaterally. This was described on the right wrist exam dated 2 Mar 05 and has not changed. The diastasis on the left is not as great as on the right.

K. L. Laybourn, MD
FCC Petersburg, Virginia
for
Observe

Signature	Location of Radiologic Facility
William B. Olson, M.D.	DBI Radiology, Inc. Franklin, Virginia 23851-1205

Original - Medical Record; Copy - Physician; Copy - Radiology
(This form may be replicated via WP)

BP-S622.060 **RADIOLOGIC CONSULTATION REQUEST/REPORT** CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Patient Identification Name, Register Number, Institution	Age	Sex	EXAMINATION REQUESTED
Hill, Kenny 17110-016 FCC - Petersburg (LOW)	42	M	Wrist - 1v (73100)
	Pregnant ___Yes X No		
	Requested by: Luis A. Negron, PA		Date Requested: 2-23-05

Specific reason(s) for request (Complaints and findings)

Widening of the scapholunate joint.

Date of examination	Date of Report	Date of Transcription	Film #
3-2-05	3-6-05		

Radiologic Report

Exam: Right Wrist - PA clench fist view.

Conclusion: Diastatic scapholunate joint.

Findings: There is no acute fracture or significant bony abnormality. There is diastasis of the scapholunate joint space, consistent with a scapholunate ligament avulsion.

3-10-05

Signature	Location of Radiologic Facility
William B. Olson, M.D.	DBI Radiology, Inc. Franklin, Virginia 23851-1205

Original - Medical Record; Copy - Physician; Copy - Radiology
(This form may be replicated via WP)

BP-S622.060 AUG 96

RADIOLOGIC CONSULTATION REQUEST/REPORT CDFRM

U.S. DEPARTMENT OF JUSTICE — **FEDERAL BUREAU OF PRISONS**

Patient Identification Name, Register Number, Institution	Age	Sex	EXAMINATION REQUESTED
Hill, Kenny 17110-016 FCC - Petersburg (LOW)	42	M	Chest - 2v (71020)
	Pregnant ___Yes X No		
	Requested by: Richard S. Forth, ARNP		Date Requested: 10-18-04

Specific reason(s) for request (Complaints and findings)

Asbestos exposure.

Date of examination	Date of Report	Date of Transcription	Film #
10-18-04	10-26-04		

Radiologic Report

Exam: PA & lateral chest.

Conclusion: Normal chest.

Findings: The heart, lungs, and bony thorax are normal. There are no parenchymal or pleural changes of asbestosis.

11/01/04
RICHARD S FORTH, ARNP

Dr. K. [illegible]
Medical Director
FCC Petersburg, Virginia

Signature	Location of Radiologic Facility
William B. Olson, MD William B. Olson, M.D.	DBI Radiology, Inc. Franklin, Virginia 23851-1205

Original - Medical Record; Copy - Physician; Copy - Radiology
(This form may be replicated via WP)

BP-S620.060 **PATIENT PROBLEM LIST** CDFRM
AUG 96
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

PROBLEM LIST

DATE NOTED	SIGNIFICANT DIAGNOSES	SIGNIFICANT OPERATIONS/ INVASIVE PROCEDURES	DATE
	E.H.M.		
6/3/04	GSW-LLE, 1980		
6/3/04	Environmental allergies		
12/6/05	Care level 2		

6/3/04
✓ NKDA
& Food
Environment - Dust & Seasonal

ADVERSE / ALLERGIC
DRUG REACTIONS
(If none, record "No Known Drug Allergies)

Patient Identification
(Name, Reg #, DOB)

(This form may be replicated via WP)

HILL,KENNETH 17110-016

7/17/62

FCC PETERSBURG, VA LOW

Ord.Date 09/20/04 HILL, KENNY 17110-016 — R. FORTH — (0)Refills
Exp.Date 10/03/04 APPLY TO LESION TWICE DAILY
Rx # 90739 TOLNAFTATE CREAM 1% GM #1

Ord.Date 09/27/04 HILL, KENNY 17110-016 — J. FAJARDO — (0)Refills
Exp.Date 10/26/04 APPLY TO AFFECTED AREA TWO TIMES DAILY
Rx # 91124 NYSTATIN & TRIAMCINOLONE CREAM GM #1

Ord.Date 05/18/05 HILL, KENNY 17110-016 — L. KHAN 7:00 — (0)Refills
Exp.Date 05/24/05 TAKE ONE CAPSULE 3 TIMES A DAY FOR 7 DAYS (4 CAPSULES ALREADY GIVEN) 11:30
Rx # 100023 AMOXICILLIN 250 MG CAP #21 20:00

Ord.Date 06/03/05 HILL, KENNY 17110-016 — R. FORTH 7:00 — (1)Refills
Exp.Date 06/17/05 APPLY SPARINGLY TWICE DAILY FOR 15 DAYS
Rx # 100411 TRIAMCINOLONE CREAM 0.1 % GM #1 20:00

Ord.Date 06/03/05 HILL, KENNY 17110-016 — R. FORTH — (0)Refills 11:30
Exp.Date 07/02/05 USE DAILY DURING SHOWER
Rx # 100412 KETOCONAZOLE 1% SHAMPOO #1

Ord.Date 08/09/05 HILL, KENNY 17110-016 — A. ZAYAS — (0)Refills
Exp.Date 08/22/05 TAKE 1 TAB TWICE DAILY
Rx # 101881 SULFAMETHOXAZOLE/TRIMETH 800MG/160MG TAB #28

FCI MCKEAN PHARMACY

134353 J. GLENN,NP 08/19/02
HILL, KENNY 17110-016
MCKEAN HOUSING FACILITY - B02-235L
APPLY TO AFFECTED AREA TWO TIMES A DAY

CLOTRIMAZOLE 1% CRM #1
(1)Refills 08/19/2002 CDM RxExp 10/17/02

CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

Ord.Date 09/13/02 HILL, KENNY 17110-016 J. GLENN (0)Refills
Exp.Date 10/12/02
APPLY TO FEET TWICE DAILY
Rx # 135630 CLOTRIMAZOLE 1% CRM #1

Ord.Date 01/07/03 HILL, KENNY 17110-016 G. FAIRBANKS (2)Refills
Exp.Date 03/07/03
APPLY TO AFFECTED AREA TWO TIMES A DAY **EXTERNAL USE ONLY**
Rx # 141276 CLOTRIMAZOLE CREAM 1% GM #1

Ord.Date 03/27/03 HILL, KENNY 17110-016 S. LABROZZI (5)Refills
Exp.Date 07/24/03
APPLY SPARINGLY TO AFFECTED AREA TWICE DAILY **EXTERNAL USE ONLY**
Rx # 145314 MICONAZOLE CREAM 2% GM #1

Ord.Date 03/27/03 HILL, KENNY 17110-016 S. LABROZZI (2)Refills
Exp.Date 09/25/03
APPLY SPARINGLY TO AFFECTED AREA TWICE DAILY **EXTERNAL USE ONLY**
Rx # 145315 BETAMETHASONE VAL 0.1% CRM #1

Ord.Date 10/31/03 HILL, KENNY 17110-016 B. SAYLOR (1)Refills
Exp.Date 12/29/03
APPLY TO AFFECTED AREA TWO TIMES A DAY **EXTERNAL USE ONLY**
Rx # 157781 CLOTRIMAZOLE CREAM 1% GM #1

Ord.Date 01/30/03 HILL, KENNY 17110-016 B. SAYLOR (2)Refills
Exp.Date 04/29/03
APPLY TO AFFECTED AREA TWO TIMES A DAY
Rx # 142259 TOLNAFTATE CREAM 1% GM #1

Ord.Date 04/14/03 HILL, KENNY 17110-016 S. LABROZZI (3)Refills
Exp.Date 07/12/03
INHALE 2 PUFFS IN EACH NOSTRIL 4 TIMES A DAY AND AS NEEDED
Rx # 146392 SALINE NASAL SPRAY #1

Ord.Date 04/14/03 HILL, KENNY 17110-016 S. LABROZZI (3)Refills
Exp.Date 07/12/03
TAKE ONE TABLET FOUR TIMES DAILY AS NEEDED FOR HEADACHES
Rx # 146393 IBUPROFEN 400 MG TAB #30

Ord.Date 09/04/03 HILL, KENNY 17110-016 R. PIOTROWSKI (1)Refills
Exp.Date 12/02/03
APPLY TO AFFECTED AREA TWO TIMES A DAY
Rx # 154312 HYDROCORTISONE 1% CRM #1

Ord.Date 09/04/03 HILL, KENNY 17110-016 R. PIOTROWSKI (1)Refills
Exp.Date 11/02/03
TAKE ONE CAPSULE EVERY 4 TO 6 HOURS AS NEEDED
Rx # 154313 DIPHENHYDRAMINE 25 MG CAP #20

Ord.Date 09/04/03 HILL, KENNY 17110-016 R. PIOTROWSKI (1)Refills
Exp.Date 12/02/03
SOAK AREA FOR 5 MIN. APPLY SIZED PATCH TO AREA AND LEAVE ON FOR 48 HOURS. REMOVE THEN REPEAT PROCESS
Rx # 154314 SALICYLIC ACID PLASTER 40% EA #1

Ord.Date 01/19/06 HILL, KENNY 17110-016 K. LAYBOURNE (0)Refills
Exp.Date 02/17/06
TAKE ONE TABLET TWICE DAILY
Rx # 104621 DOXYCYCLINE HYCLATE 100MG TAB #60

Ord.Date 02/19/04 HILL, KENNY 17110-016 S. LABROZZI (1)Refills
TAKE ONE TABLET WITH FOOD OR MILK ITD AS NEEDED FOR PAIN
Rx # 163560 IBUPROFEN 800 MG TAB #30

Ord.Date 02/19/04 HILL, KENNY 17110-016 S. LABROZZI (0)Refills
Exp.Date 02/19/04
SOAK AREA FOR 5 MIN. CUT & FIT TO SIZE OF AREA & APPLY FOR 48 HOURS. REMOVE PLASTER & DEAD SKIN. REPEAT AS NEEDED **FURTHER REFILLS FROM COMMISSARY**
Rx # 163561 SALICYLIC ACID PLASTER 40% EA #2

FCI MCKEAN PHARMACY
116048 W. FLATT 06/05/01
HILL, KENNY 17110-016
MCKEAN HOUSING FACILITY - B02-235L
APPLY TO AFFECTED AREA TWO
TIMES A DAY **EXTERNAL USE ONLY**

OLNAFTATE CREAM 1% GM #1
(0)Refills 06/05/2001 CLO RxExp 08/03/01

FCI MCKEAN PHARMACY
16227 D. OLSON 06/08/01
LL, KENNY 17110-016
CKEAN HOUSING FACILITY - B02-235L
PLY TO AFFECTED AREA TWO
MES A DAY **EXTERNAL USE ONLY**

/DROCORTISONE CREAM 1% GM #1
Refills 06/08/2001 CLO RxExp 07/07/01

CI MCKEAN PHARMACY
118207 J. GOMEZ-LEO 08/03/01
ILL, KENNY 17110-016
CKEAN HOUSING FACILITY - B02-235L
PPLY TO AFFECTED AREA TWO
IMES A DAY **EXTERNAL USE ONLY**

LOTRIMAZOLE 1% CRM #1
)Refills 08/03/2001 DAO RxExp 10/31/01
CAUTION: Federal/State law prohibits transfer of this drug

CI MCKEAN PHARMACY
118484 G. FAIRBANKS 08/14/0
ILL, KENNY 17110-01
CKEAN HOUSING FACILITY - B02-235L
PPLY TO AFFECTED AREA TWO
IMES A DAY **EXTERNAL USE ONLY**

OLNAFTATE CREAM 1% GM #
)Refills 08/14/2001 DAO RxExp 10/12/

CI MCKEAN PHARMACY
118784 G. FAIRBANKS 08/21/0
ILL, KENNY 17110-016
CKEAN HOUSING FACILITY - B02-235L
PPLY TO AFFECTED AREA TWO
IMES A DAY **EXTERNAL USE ONLY**

LOTRIMAZOLE 1% CRM #
)Refills 08/21/2001 DAO RxExp 11/18/0
CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

FCI McKean
P.O. Box 5000
Bradford, PA 16701

FCI MCKEAN PHARMACY
125032 B. SAYLOR,NP
HILL, KENNY 17
MCKEAN HOUSING FACILITY - B0
TAKE ONE TABLET EVERY EIGH
HOURS WITH FOOD

IBUPROFEN 400 MG TAB
(0)Refills 01/22/2002 CDM RxExp

FCI MCKEAN PHARMACY
125033 B. SAYLOR,NP 0
HILL, KENNY 171
MCKEAN HOUSING FACILITY - B02
APPLY TO AFFECTED AREA TWO
TIMES A DAY **EXTERNAL USE O

CLOTRIMAZOLE 1% CRM
(1)Refills 01/22/2002 CDM RxExp
CAUTION: Federal/State law prohibits transfer of this

FCI MCKEAN PHARMACY
130560 B. SAYLOR 05/23/02
HILL, KENNY 17110-016
MCKEAN HOUSING FACILITY - B02-235L
APPLY TO AFFECTED AREA TWO
TIMES A DAY **EXTERNAL USE ONLY**

D/C 8/19 New Rx

CLOTRIMAZOLE 1% CRM #1
(2)Refills 05/23/2002 CDM RxExp 08/20/02

FCI MCKEAN PHARMACY
131404 B. SAYLOR 06/13/02
HILL, KENNY 17110-016
MCKEAN HOUSING FACILITY - B02-235L
APPLY TO AFFECTED AREA TWO
TIMES A DAY **EXTERNAL USE ONLY**

HYDROCORTISONE CREAM 1% GM #1
(1)Refills 06/13/2002 CDM RxExp 07/12/02
CAUTION: Federal/State law prohibits transfer of this drug

FCI MCKEAN PHARMACY
132616 J. GLENN,NP 07/11/02
HILL, KENNY 17110-016
MCKEAN HOUSING FACILITY - B02-235L
APPLY TO AFFECTED AREA TWO
TIMES A DAY SPARINGLY **EXTERNAL
USE ONLY** (APPLY TO ARMS AND
NECK)

HYDROCORTISONE 1% CRM #1
(0)Refills 07/11/2002 CDM RxExp 08/09/02
CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

FCI MCKEAN PHARMACY
132617 J. GLENN,NP 07/11/02
HILL, KENNY 17110-016
MCKEAN HOUSING FACILITY - B02-235L
APPLY TO FEET TWICE DAILY
EXTERNAL USE ONLY

D/C 8/19 New Rx

CLOTRIMAZOLE 1% CRM #1
(1)Refills 07/11/2002 CDM RxExp 09/08/02
CAUTION: Federal/State law prohibits transfer of this drug

FCI MCKEAN PHARMACY
133937 G. FAIRBANKS 08/08/02
HILL, KENNY 17110-016
MCKEAN HOUSING FACILITY - B02-235L
APPLY TO AFFECTED AREA TWO
TIMES A DAY **EXTERNAL USE ONLY**

HYDROCORTISONE 1% CRM #1
(1)Refills 08/08/2002 CDM RxExp 10/06/02
CAUTION: Federal/State law prohibits transfer of this drug to any person other than patient for whom prescribed.

Rx # 163560 Exp.Date 02/19/05 Ord.Date 02/19/04
HILL, KENNY 17110-016
IBUPROFEN 800 MG TAB
TAKE ONE TABLET WITH FOOD OR MILK THREE TIMES DAILY AS NEEDED FOR PAIN
S. LABROZZI (1)Refills #30

Rx # 168107 Exp.Date 07/28/04 Ord.Date 05/28/04
HILL, KENNY 17110-016
INDOMETHACIN 25 MG CAP
TAKE 1 TO 2 CAPSULES WITH FOOD OR MILK THREE TIMES DAILY
S. LABROZZI (1)Refills #42

NAME: Hill, Kenny Reg. No. 17110-0

BP-S619.060 **IMMUNIZATION RECORD** CDFRM
AUG 96
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TETANUS TOXOIDS

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION
6-00	Baltimore	DOC MRDCC per inmate					

TUBERCULIN TESTS

DATE GIVEN	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION	DATE READ	RESULTS (MM)	READ BY
					Pen BP149		6/28/00	0 MM	
6/4/01	Aventis	C0G3CAA	5/02	LFA	0.1ml ID	FLMCKEAN.	6/6/01	0x0	Nurse
6/5/02	Aventis	C09B4AA	5-14-04	LFA	0.1cc ID	FCI McKean PA	6/7/02	0x0	
6/3/03	Park.	007328	9/03	LFA	0.1cc ID	MCKEAN PA	6/5/03	0x0	
6/8/04	Park.	001827	8/04	LFA	0.1cc ID	MCKEAN PA	6/10/04	0x0	
5/25/05	Parkedale	002748	05/06	LFA	0.1cc/ID	FCC McKean PA	5/27/05	0mm	Nurse

Patient Identification
(Name, Reg #)

(This form may be replicated via WP)

HILL,KENNETH 17110-016

MEDICAL RECORD — **REPORT OF MEDICAL EXAMINATION**

DATE OF EXAM: 12/4/02

1. LAST NAME–FIRST NAME–MIDDLE NAME: KENNY EARL HILL
2. IDENTIFICATION NUMBER: 17110-016
3. GRADE AND COMPONENT OR POSITION:
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code): 2607 LORRING DR DISTRICT HGTS, MD. 20747
5. EMERGENCY CONTACT (Name and address of contact): CAROLITA LITTLE FRIEND
6. DATE OF BIRTH: 7-17-62
7. AGE: 40
8. SEX: ☐ FEMALE ☒ MALE
9. RELATIONSHIP OF CONTACT: FRIEND
10. PLACE OF BIRTH: WASHINGTON, D.C.
11. RACE: ☐ WHITE ☒ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER
12a. AGENCY: BOP / DOJ
12b. ORGANIZATION UNIT: McKean
13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY: b. CIVILIAN:
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS: P.O. Box 5000 Bradford, PA 16701
15. RATING OR SPECIALTY OF EXAMINER:
16. PURPOSE OF EXAMINATION: Bi-Annual

17. CLINICIAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	A. HEAD, FACE, NECK AND SCALP	
✓	B. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)	
✓	C. DRUMS (Perforation)	
✓	D. NOSE	
✓	E. SINUSES	
✓	F. MOUTH AND THROAT	
✓	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)	
✓	H. OPHTHALMOSCOPIC	
✓	I. PUPILS (Equality and reaction)	
✓	J. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	K. LUNGS AND CHEST	
✓	L. HEART (Thrust, size, rhythm, sounds)	
✓	M. VASCULAR SYSTEM (Varicosities, etc.)	
✓	N. ABDOMEN AND VISCERA (Include hernia)	
✓	O. PROSTATE (Over 40 or clinically indicated)	
✓	P. TESTICULAR	
✓	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
✓	R. ENDOCRINE SYSTEM	
✓	S. G-U SYSTEM	
✓	T. UPPER EXTREMITIES (Strength, range of motion)	
✓	U. FEET	
✓	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	W. SPINE, OTHER MUSCULOSKELETAL	
	X. IDENTIFYING BODY MARKS, SCARS, TATTOOS See below	
✓	Y. SKIN, LYMPHATICS	
✓	Z. NEUROLOGIC (Equilibrium tests under item 41)	
✓	AA. PSYCHIATRIC (Specify any personality deviation)	
N/A	BB. BREASTS	
N/A	CC. PELVIC (Females only)	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)
Tattos - (R) + (L) F Arm, (L) Chest

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth: 1 2 3 / 32 31 30 0
Non-restorable teeth: 1 2 3 / 32 31 30 /
Missing Teeth: 1 2 3 / 32 31 30 X
Replaced by Dentures: X X X / 32 31 30 X X X
Fixed Partial Dentures: [X] / 32 31 30 [X]

RIGHT: 1 2 3 4 5 6 7 8 / 32 31 30 29 28 27 26 25
LEFT: 9 10 11 12 13 14 15 16 / 24 23 22 21 20 19 18 17

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES:

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY
(2) URINE ALBUMIN
(3) URINE SUGAR
(4) MICROSCOPIC
B. CHEST X-RAY OR PPD (Place, date, film number and result)
C. SYPHILIS SEROLOGY (Specify test used and results)
D. EKG
E. BLOOD TYPE AND RH FACTOR
F. OTHER TESTS

NSN 7540-00-634-4038
88-126

STANDARD FORM 88 (Rev. 10-94)
Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

NAME: Dell, Kenneth | IDENTIFICATION NUMBER: 17118-016 | NO. OF SHEETS ATTACHED:

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
6' 1"	214 1/2	Black	Brown	☐ SLENDER ☑ MEDIUM ☐ HEAVY ☐ OBESE	97.8

26. BLOOD PRESSURE *(Arm at heart level)*

		A. SITTING	B. RECUMBENT	C. STANDING (5 mins.)
SYS.		116		
DIAS.		60		

27. PULSE *(Arm at heart level)*

A. SITTING	B. RECUMBENT	C. STANDING (3 mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER
76				

28. DISTANT VISION		29. REFRACTION			30. NEAR VISION	
RIGHT 20/ 15	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/ 15	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION *(Test used and score)*	
RIGHT WNL	LEFT WNL	WNL		UNCORRECTED
				CORRECTED

35. FIELD OF VISION		36. NIGHT VISION *(Test used and score)*	37. RED LENS TEST	38. INTRAOCULAR TENSION	
RIGHT WNL	LEFT WNL			RIGHT	LEFT

39. HEARING			40. AUDIOMETER								41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
				250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT WV	/15 SV	/15	RIGHT								
LEFT WV	/15 SV	/15	LEFT								

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

* Ø Known exposure to infectious
* Ø HIV STD's
* Ø HIV IVDA

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE *(Check)*
A. ☑ IS QUALIFIED FOR General duty
B. ☐ IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

48. TYPED OR PRINTED NAME OF PHYSICIAN: Gracia Fairbanks | SIGNATURE: Gracia Fairbanks MD

49. TYPED OR PRINTED NAME OF PHYSICIAN: H. BEAM, MD / FCI McKEAN | SIGNATURE: Gracia Fairbanks, MLP

50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)* | SIGNATURE

51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY | SIGNATURE

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION

DATE OF EXAM: 7-12-02

1. LAST NAME–FIRST NAME: HILL,KENNETH 17110-016

2. IDENTIFICATION NUMBER:

3. GRADE AND COMPONENT OR POSITION:

4. HOME ADDRESS (Numbe:

5. EMERGENCY CONTACT (Name and address of contact): Anna Prentiss 4419 ~~Suitland~~ Arnold Rd Suitland MD 20746 (301)736-2420

6. DATE OF BIRTH: 7-17-62

7. AGE: 37

8. SEX: ☐ FEMALE ☒ MALE

9. RELATIONSHIP OF CONTACT: Mother

10. PLACE OF BIRTH: Washington DC

11. RACE: ☐ WHITE ☒ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER

12a. AGENCY: D.O.J.

12b. ORGANIZATION UNIT: B.O.P.

13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY — b. CIVILIAN —

14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS:

U.S. PENITENTIARY
TERRE HAUTE, IN 47808

15. RATING OR SPECIALTY OF EXAMINER: PA-C

16. PURPOSE OF EXAMINATION: Intake Physical

17. CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	A. HEAD, FACE, NECK AND SCALP	
✓	B. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)	
✓	C. DRUMS (Perforation)	
✓	D. NOSE	
✓	E. SINUSES	
✓	F. MOUTH AND THROAT	
✓	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)	
NE	H. OPHTHALMOSCOPIC	
✓	I. PUPILS (Equality and reaction)	
✓	J. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	K. LUNGS AND CHEST	
✓	L. HEART (Thrust, size, rhythm, sounds)	
✓	M. VASCULAR SYSTEM (Varicosities, etc.)	
✓	N. ABDOMEN AND VISCERA (Include hernia)	
NE	O. PROSTATE (Over 40 or clinically indicated)	
✓	P. TESTICULAR	
NE	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
✓	R. ENDOCRINE SYSTEM	
✓	S. G-U SYSTEM	
✓	T. UPPER EXTREMITIES (Strength, range of motion)	
✓	U. FEET	
✓	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	W. SPINE, OTHER MUSCULOSKELETAL	
✓	X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	Y. SKIN, LYMPHATICS	
✓	Z. NEUROLOGIC (Equilibrium tests under item 41)	
✓	AA. PSYCHIATRIC (Specify any personality deviation)	
NE	BB. BREASTS	
NE	CC. PELVIC (Females only)	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

O, Q – Pt. deferred exam @ this time. Pt. told about S/S of to be aware of and to seek examination if they occur. Kenneth Hill

X = tatoos x3 both arms and chest

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth: 0 / 1 2 3 / 32 31 30
Non-restorable teeth: / / 1 2 3 / 32 31 30
Missing Teeth: X / 1 2 3 / 32 31 30
Replaced by Dentures: X X X / 1 2 3 / 32 31 30 / X X X
Fixed Partial Dentures: (X) / 1 2 3 / 32 31 30 / (X)

RIGHT																LEFT
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY
(2) URINE ALBUMIN
(3) URINE SUGAR
(4) MICROSCOPIC

B. CHEST X-RAY OR PPD (Place, date, film number and result)

C. SYPHILIS SEROLOGY (Specify test used and results)

D. EKG

E. BLOOD TYPE AND RH FACTOR

F. OTHER TESTS

NSN 7540-00-634-4038
88-126

STANDARD FORM 88 (Rev. 10-94)
Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

NAME	IDENTIFICATION NUMBER	NO. OF SHEETS ATTACHED
Hill, Kenneth	17110-016	

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
6' 1"	208#	Brn	Brn	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	97

26. BLOOD PRESSURE (Arm at heart level)						27. PULSE (Arm at heart level)				
A. SITTING	SYS. 107 / DIAS. 65	B. RECUMBENT	SYS. / DIAS.	C. STANDING (5 mins.)	SYS. / DIAS.	A. SITTING 52	B. RECUMBENT	C. STANDING (3 mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER

28. DISTANT VISION		29. REFRACTION			30. NEAR VISION	
RIGHT 20/ 20	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/ 20	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

31. HETEROPHORIA (Specify distance)

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION (Test used and result)	34. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT	14/14 ISHIHARA		CORRECTED
35. FIELD OF VISION		36. NIGHT VISION (Test used and score)	37. RED LENS TEST	38. INTRAOCULAR TENSION
RIGHT	LEFT			RIGHT / LEFT

39. HEARING			40. AUDIOMETER								41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
				250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
RIGHT WV	/15 SV	/15	RIGHT		WNH	WNH	40		40			
LEFT WV	/15 SV	/15	LEFT		WNH	WNH	40		20			

42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY WNH = Not Heard

S.H.: no tobacco use. 2 children. single

F.M.H mother - Healthy
father - "

maternal GM - deceased from lung CA
GF - Healthy

paternal GM - deceased from heart attack
GF - healthy

N/A

1. Medical (Including Tuberculosis, Hepatitis, Diabetes & Heart Disease)	0 / 0 / 0 / 0
2. Surgical	none
3. Allergies	NKDA
4. Venereal Disease	none
5. Drug dependence	1 - Non-user; 2 - Former user; 3 - Recent user; 4 - User (immediate past); 5 - User (not withdrawn)
6. Type of drug	1 - Marijuana; 2 - Narcotics; 3 - Hallucinogens; 4 - Barbiturates; 5 - Psycho-stimulants; 6 - Other
7. Alcoholism	1 - Non-significant use; 2 - Former excessive use; 3 - Binge use; 4 - Habitual excessive use; 5 - Other

one brother, one sister ~ Healthy

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

37y.o. black OF A & O x 3. PPD on 6/28/00 neg. F

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE (Check)
A. ☒ IS QUALIFIED FOR reg. duty, reg. housing
B. ☐ IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
P. Iwaim PA-C	P. Iwaim PA-C
49. TYPED OR PRINTED NAME OF PHYSICIAN G. Lawson, M.D. Clinical Director	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)	SIGNATURE
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE N

HILL
KENNY 17110-016
B/M/O/07-17-1962
HT/601 WT/226 HR/BK EY/BN
CUSTODY/IN
FCC Petersburg, FPM

3. PURPOSE OF EXAMINATION

6. STATEMENT OF EXAMINEE'S PRESEN *(st history, if complaint arises)*

42 y/o male
NKDA
NO Meds.

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever		✓		or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
✓			Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine		✓		homosexual contact?
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
	✓		Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓		Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis		✓		Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity		✓		Cocaine
	✓		Thyroid trouble		✓		Lameness		✓		Heroin
	✓		Tuberculosis		✓		Loss of finger or toe		✓		L.S.D.
	✓		Asthma		✓		Painful or "Trick"shoulder or elbow		✓		Amphetamines
	✓		Shortness of breath		✓		Recurrent back pain		✓		Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
	✓		Chronic cough		✓		Foot trouble				Alcohol or drug
	✓		Palpitation or pounding heart		✓		Neuritis				Withdrawal Problems
	✓		Heart trouble		✓		Paralysis (include infantile)				
	✓		High or low blood pressure								
	✓		Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
	✓		Frequent indigestion								Been treated for a female disorder
	✓		Stomach, liver, or intestinal trouble								Had a change in menstrual pattern
	✓		Gall bladder trouble or gallstones								ARE YOU PREGNANT
	✓		Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☒ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
		C. Inability to assume certain positions.			
		D. Other medical reasons *(If yes, give reasons.)*		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
		15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13-22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: Steven E. Eichhold

SIGNATURE: Steven E. Eichhold

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ✓ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE

THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? None

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK HW RESTRICTED ____

GENERAL POPULATION ✓ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION HW

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

- no suicidal ideation

A. Yirge, PA
FCI Peter...

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
	8/20/04		

REVERSE

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER	5. EXAMINING FACILITY
Hall, Lewis Earl	17110-016	Health Services Unit FDC Philadelphia
3. PURPOSE OF EXAMINATION	**4. DATE OF EXAMINATION**	
Institution Entry	8/23/04	

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

Excellent Health

NO KNOWN DRUG ALLERGIES.

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever
	✓		Rheumatic fever
	✓		Swollen or painful joints
✓		(1)	Frequent or severe headache
	✓		Dizziness or fainting spells
	✓		Eye trouble
	✓		Ear, nose, or throat trouble
	✓		Hearing loss
	✓		Chronic or frequent colds
	✓		Severe tooth or gum trouble
	✓		Sinusitis
✓	✓	(2)	Hay Fever
	✓		Head injury
	✓		Skin diseases
	✓		Thyroid trouble
	✓		Tuberculosis
	✓		Asthma
	✓		Shortness of breath
	✓		Pain or pressure in chest
	✓		Chronic cough
	✓		Palpitation or pounding heart
	✓		Heart trouble
	✓		High or low blood pressure
	✓		Cramps in your legs
	✓		Frequent indigestion
	✓		Stomach, liver, or intestinal trouble
	✓		Gall bladder trouble or gallstones
	✓		Jaundice or hepatitis

YES	NO	DON'T KNOW	(Check each item)
	✓		Adverse reaction to serum drug or medicine
	✓		Broken bones
	✓		Tumor, growth, cyst, cancer
	✓		Rupture/hernia
	✓		Piles or rectal disease
	✓		Frequent or painful urination
	✓		Bed wetting since age 12
	✓		Kidney stone or blood in urine
	✓		Sugar or albumin in urine
	✓		VD—Syphilis, gonorrhea, etc.
	✓		Recent gain or loss of weight
	✓		Arthritis, Rheumatism, or Bursitis
	✓		Bone, joint or other deformity
	✓		Lameness
	✓		Loss of finger or toe
	✓		Painful or "Trick"shoulder or elbow
	✓		Recurrent back pain
	✓		"Trick" or locked knee
	✓		Foot trouble
	✓		Neuritis
	✓		Paralysis (include infantile)

YES	NO	DON'T KNOW	(Check each item)
	✓		Epilepsy or fits
	✓		Car, train, sea or air sickness
	✓		Frequent trouble sleeping
	✓		Depression or excessive worry
	✓		Loss of memory or amnesia
	✓		Nervous trouble of any sort
	✓		Periods of unconsciousness
	✓		Have you ever had homosexual contact?
	✓		Been exposed to AIDS
	✓		Alcohol Use (Excessive)
	✓		Drug Use/Addiction
	✓		Marijuana
	✓		Cocaine
	✓		Heroin
	✓		L.S.D.
	✓		Amphetamines
	✓		Others: (Specify)
	✓		Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)

☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLA.. D IN BLANK SPACE BELOW

ES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

XPLANATION: (#13-22 ABOVE)

certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the octors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

YPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

ITAKE SCREENING:

MATE RECEIVED FROM: COURT ___ TRANSFER ✓ P.V. ___

THER FCI MCK

EDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE IRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, PPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, UNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORM-IES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, OW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE

THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? NJ

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? N/A

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED ___

GENERAL POPULATION ✓ YES ___ NO ___

TYPE AND EXTENT OF LIMITATION ___

. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

) H/o occasional H/A to c Motrin
) H/o Hay fever since childhood

PED OR PRINTED NAME OF PHYSICIAN OR AMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
R. Ritter, MLP FDC Philadelphia	8/23/04		

ERSE

U.S. Department of Justice **MEDICAL HISTORY REPORT**

Federal Bureau Of Prisons

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
HULL KENNY EARL	17110-016

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake Screening	4/6/01	FCI McKean

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

E.H.M. 38 y/o Caucasian male
No meds. NKDA

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever		✓		or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine				homosexual contact?
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
	✓		Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓		Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis		✓		Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity		✓		Cocaine
	✓		Thyroid trouble		✓		Lameness		✓		Heroin
	✓		Tuberculosis		✓		Loss of finger or toe		✓		L.S.D.
	✓		Asthma		✓		Painful or "Trick"shoulder or elbow		✓		Amphetamines
	✓		Shortness of breath	✓			Recurrent back pain		✓		Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
	✓		Chronic cough		✓		Foot trouble		✓		Alcohol or drug
	✓		Palpitation or pounding heart		✓		Neuritis				Withdrawal Problems
	✓		Heart trouble		✓		Paralysis (include infantile)				
	✓		High or low blood pressure								
	✓		Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
	✓		Frequent indigestion								Been treated for a female disorder
	✓		Stomach, liver, or intestinal trouble								Had a change in menstrual pattern
	✓		Gall bladder trouble or gallstones								ARE YOU PREGNANT
	✓		Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☑ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13-22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: Kenneth Hall

SIGNATURE: Kenneth Hall

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ✓ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? NO

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ (NO) ____

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ✓ RESTRICTED ____

GENERAL POPULATION ____ (YES) ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

No change medical status

TYPED OR PRINTED NAME OF PHYSICIAN, OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
J. Gomez, MD	4/6/01		

REVERSE

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
T[illegible] EDWARD E.	17110-[illegible]

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
		U.S. PENITENTIARY TERRE HAUTE, IN 47808

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
	✓	✓	Scarlet fever
	✓	✓	Rheumatic fever
	✓	✓	Swollen or painful joints
	✓		Frequent or severe headache
	✓		Dizziness or fainting spells
	✓		Eye trouble
			Ear, nose, or throat trouble
	✓		Hearing loss
	✓		Chronic or frequent colds
	✓		Severe tooth or gum trouble
	✓		Sinusitis
			Hay Fever
	✓		Head injury
	✓		Skin diseases
	✓		Thyroid trouble
	✓		Tuberculosis
	✓		Asthma
	✓		Shortness of breath
	✓		Pain or pressure in chest
	✓		Chronic cough
	✓		Palpitation or pounding heart
	✓		Heart trouble
	✓		High or low blood pressure
	✓		Cramps in your legs
	✓		Frequent indigestion
	✓		Stomach, liver, or intestinal trouble
	✓		Gall bladder trouble or gallstones
	✓		Jaundice or hepatitis

YES	NO	DON'T KNOW	(Check each item)
	✓		Adverse reaction to serum drug or medicine
	✓		Broken bones
	✓		Tumor, growth, cyst, cancer
	✓		Rupture/hernia
	✓		Piles or rectal disease
	✓		Frequent or painful urination
	✓		Bed wetting since age 12
	✓		Kidney stone or blood in urine
	✓		Sugar or albumin in urine
	✓		VD—Syphilis, gonorrhea, etc.
	✓		Recent gain or loss of weight
	✓		Arthritis, Rheumatism, or Bursitis
	✓		Bone, joint or other deformity
	✓		Lameness
	✓		Loss of finger or toe
	✓		Painful or "Trick" shoulder or elbow
X	✓		Recurrent back pain
	✓		"Trick" or locked knee
	✓		Foot trouble
	✓		Neuritis
	✓		Paralysis (include infantile)

YES	NO	DON'T KNOW	(Check each item)
	✓		Epilepsy or fits
	✓		Car, train, sea or air sickness
	✓		Frequent trouble sleeping
	✓		Depression or excessive worry
	✓		Loss of memory or amnesia
	✓		Nervous trouble of any sort
	✓		Periods of unconsciousness
	✓		Have you ever had homosexual contact?
	✓		Been exposed to AIDS
	✓		Alcohol Use (Excessive)
	✓		Drug Use/Addiction
	✓		Marijuana
	✓		Cocaine
	✓		Heroin
	✓		L.S.D.
	✓		Amphetamines
	✓		Others: (Specify)
	✓		Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

			(Check each item)
			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☑ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
✓		13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.			
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
✓	■	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13-22 ABOVE)

certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE

SIGNATURE

NTAKE SCREENING:

NMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

)THER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, AUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

F DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ____

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION ____ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

3. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

G. Lawson, M.D.
Clinical Director
7-6-00

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
D. Ferris RN	7-5-00		

VERSE

BP-S360.060 MEDICAL HISTORY REPORT CDFRM MAY 1994

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME	2. REGISTER NUMBER
HILL, KENNETH E.	

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake Screening		Federal Transfer Center, Oklahoma City, OK

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises)

7. HAVE YOU EVER (Please check each item)

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU (Please check each item)

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to		✓		Epilepsy or fits
	✓		Rheumatic fever		✓		drug or medicine		✓		Car,train,sea or air sickness
	✓		Swollen or painful		✓		Broken bones		✓		Frequent trouble sleeping
	✓		joints		✓		Tumor,growth,cyst,cancer		✓		Depression or excessive worry
	✓		Frequent or severe		✓		Rupture/hernia		✓		Loss if memory or amnesia
✓			headache		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Dizziness or fainting		✓		Frequent or		✓		Periods of unconsciousness
	✓		spells		✓		painful urination		✓		Have you ever had
	✓		Eye trouble		✓		Bed wetting since age 12				homosexual contact?
	✓		Ear,nose,throat trouble		✓		Kidney stone or		✓		Been exposed to AIDS
	✓		Hearing loss		✓		blood in urine		✓		Alcohol Use (Excessive)
	✓		Chronic, frequent colds		✓		Sugar, albumin in urine		✓		Drug Use/Addiction
	✓		Sever tooth, gum trouble		✓		VD-Syphilis, gonorrhea,		✓		Marijuana
	✓		Sinusitis		✓		etc.		✓		Cocaine
	✓		Hay Fever		✓		Recent gain or loss of		✓		Heroin
	✓		Head injury		✓		weight		✓		L.S.D.
	✓		Skin diseases		✓		Arthritis, Rheumatism,		✓		Amphetamines
	✓		Thyroid trouble		✓		or Bursitis		✓		Others: (Specify)
	✓		Tuberculosis		✓		Bone, joint or				
	✓		Asthma		✓		other deformity				Alcohol or drug
	✓		Shortness of breath		✓		Lameness				Withdrawal Problems

(This form may be replicated via WP) This form replaces BP-360(60) dated January 1986.

	✓		Pain, pressure in chest		✓		Loss of finger or toe				
	✓		Chronic cough		✓		Painful or "Trick"				
	✓		Palpitation or pounding		✓		shoulder or elbow	10. FEMALES ONLY	HAVE	YOU	EVER
	✓		heart		✓		Recurrent back pain				Been treated for a
	✓		Heart trouble		✓		"Trick" or locked knee				female disorder
	✓		High or low blood		✓		Foot trouble				Had a change in
	✓		pressure		✓		Neuritis				menstrual pattern
	✓		Cramps in your legs		✓		Paralysis (include				ARE YOU PREGNANT
	✓		Frequent indigestion		✓		infantile)				SUSPECT YOU ARE PREGNANT
	✓		Stomach, liver, or		✓		Gall bladder trouble or				
	✓		intestinal trouble		✓		gallstones				
	✓		Jaundice or hepatitis								

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (check one) ☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
✓		13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury noted? (If yes, specify when, where, and give details.)
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
	✓	C. Inability to assume certain positions.			
	✓	D. Other medical reasons (If yes, give reasons.)			
	✓	14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details).	✓		20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
	✓	15. Have you ever been denied life insurance? reason and give details.)		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
	✓	16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)			
	✓	17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE | SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ___ P.V. ___ OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCKS BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED: HAVE

HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ___

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ___

WHAT ARRANGEMENTS HAVE BEEN MADE? ___

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED ___
GENERAL POPULATION ___ YES ___ NO
TYPE AND EXTENT OF LIMITATION ___

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

Brian Groneweg LPN
Registered Nurse
Federal Transfer Center, OKC, OK

JUL 03 2000

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER | SIGNATURE | NUMBER OF ATTACHED SHEETS

Food or Drug Allergies: ~~NKA~~ Allergies: ___
Current Medical Status: ~~No~~ Complaints: Complaint of ___
TB Signs and Symptom(s): ~~NONE~~ cough, hemoptysis, night sweats, wt.los

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FCC Petersburg Low	8-27-04	1300

Inmate's Name	Register Number
Hill, Kenny	17110-016

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)

2. General Population Housing Approved? ☑ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☑ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☑ no (Explain)
AES

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
V. Pegram	8-27-04	1405

Medical Staff Title
Registered Nurse

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

PRINTED ON RECYCLED PAPER

BP-S354.060 INTAKE SCREENING (MEDICAL) CDFRM

HILL
KENNY 17110-016
B/M/O/07-17-1962
HT/601 WT/226 HR/BK EY/BN
CUSTODY/IN

FCC Petersburg, PEM

HILL

FEDERAL BUREAU OF PRISONS

eening form on all arrivals to the

Arrival 8/25/04	Time of Arrival 1400
Register Number	

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☒ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks: H/O

Medical Staff Signature | Date 8/25/04 | Time 1800

Medical Staff Title A. Yirga, P.A.
FCI Petersburg

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Printed on Recycled Paper

BP-S354.060 **INTAKE SCREENIN (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FDC Philadelphia	8/23/04	1600

Inmate's Name	Register Number
Hall Kenneth	13110-016

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
[signature]	8/23/04	1935

Medical Staff Title

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

BP-S354.060 INTAKE SCREENIN (MEDICAL) CDFRM (R)
NOV 94
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP Lewisburg PA	8/20/04	1420

Inmate's Name	Register Number
Hill, Kenny	17110-016

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☐ yes; ☒ no (Specify limitation or need)
H/O

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks: NONE

Medical Staff Signature	Date	Time
Ivan Navarro PA	8/20/04	1450

Medical Staff Title Ivan Navarro, PA

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

PRINTED ON RECYCLED PAPER

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP Lewisburg Health Services Unit Lewisburg, PA 17837	08 MAR 2001	1150

Inmate's Name	Register Number
WILLIAMS, KENNARD	17140-068

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s) _____

6. Remarks: NONE

Medical Staff Signature	Date	Time
	08 MAR 01	2359

Medical Staff Title
Mark Peoria, PA-C

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

BP-S354.060 **INTAKE SCREENI (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date o

HILL
KENNY 17110-016
B/M/O/07-17-1962
HT/601 WT/226 HR/BK EY/BN
CUSTODY/IN

Inmate's Name

M E D I C A L

1. BP-149(60) reviewed? ☒ yes; ☐ no

2. General Population Housing Approved? ☐ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☐ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date MAR 28 2001	Time 1959

Medical Staff Title

Todd Genzer
Clinical Nurse
FTC, Oklahoma City, OK

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

PRINTED ON RECYCLED PAPER

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP-THA	7-6-00	1030

Inmate's Name	Register Number
Hill, Kenneth	17110-016

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? XXX☐ yes; ☐ no (Explain)

2. General Population Housing Approved? XXX☐ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; XXX☐ no (Specify limitations or exclusions)

NOT UNTIL MEDICALLY CLEARED.

4. For Holdovers: OK for Continued Transport? XXX☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes XXX☐ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:
PPD- 6-28-00 0 mm
LICE-NONE/
SUICIDAL THOUGHTS-NONE/
MEDICAL C/O'S-NONE/
ALLERGIES-NKDA/
MEDICATION-NONE/SEE 600

Medical Staff Signature	Date	Time
[signature] RN	7-6-00	1130

Medical Staff Title
C. MCCOY R.N. D. FARRIS R.N. D. LAMPING R.N.

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Printed on Recycled Paper

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFR/
NOV 94
U.S. DEPARTMENT OF JUSTICE

HILL
KENNY 17110-016
B/M/O/07-17-1962
HT/601 WT/226 HR/BK EY/BN
CUSTODY/IN

(Medical staff shall complete this scr
Institution)

Institution	Date of

Inmate's Name

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)

2. General Population Housing Approved? ☑ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☑ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☑ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
	JUL 0 3 2000	1850

Medical Staff Title

Todd Genzer
Clinical Nurse
FTC, Oklahoma City, OK

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Printed on Recycled Paper

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Dermatology | FROM: (Requesting physician or activity) Medical | DATE OF REQUEST 1/16/06

REASON FOR REQUEST (Complaints and findings)

42yWM c/o complaints of 4 day rash
rashes appear on his "scrotal area" Denies he had exposed to anything. Pt reports pruritis & pustules at irritated areas. Pt is requesting
PROVISIONAL DIAGNOSIS Dermatitis ddx.?

DOCTOR'S SIGNATURE E. Panaguiton Mid-Level Practitioner FCC Petersburg Virginia | APPROVED | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☑ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☑ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

18 Jan 06 Dermatology
Itches on arms & only after lesion on Trunk
O: Both chest abdomen & scattered inflammed pustules & papule
A- folliculitis.
P Doxycycline 100 mg BID x 1 month
F/U 1 month

(Continue on reverse side)

SIGNATURE AND TITLE Emil J Freihofner MD | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

Bill, Kenneth
17110-016

Cancel Form
1-18-06
K. L. Layburn, MD
FCC Petersburg, Virginia

Health Services Unit-Low
FCC Petersburg, VA

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Dermatology | FROM: *(Requesting physician or activity)* Medical | DATE OF REQUEST 6/3/05

REASON FOR REQUEST *(Complaints and findings)*
42 yr old male c 2-3 yr history of Pruritic Rash on Right flank area. Unresponsive to topical steroids.

PROVISIONAL DIAGNOSIS
Chronic Dermatitis

DOCTOR'S SIGNATURE R. Forth, PHS Mid-Level Practitioner | APPROVED VDD | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

16 NOV 06 Dermatology
> 2 yr Hx of pruritic papules, pustules on trunk and arms
O: Trunk, arms - scattered erythematous papules & pustules
A: ? Pityrosporin folliculitis vs Grover's disease
P- 4mm Bx of pustules R lower chest
4% (2% Epi. Betadine scrub.
DSD.
F/U 1 month

(Continue on reverse side)

SIGNATURE AND TITLE Erick J. Freckleton MD | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S ID NUMBER *(SSN or Other)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade)*
Hill, Kenny.
17 NOV 06

REGISTER NO. | WARD NO.

K. L. Lawhorn, AS
FCC Petersburg, Virginia
11-17-05

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Ortho Clinic | FROM: (Requesting physician or activity) Dr. Laybourn | DATE OF REQUEST 6/1/05

REASON FOR REQUEST (Complaints and findings)

F/U 2 months

PROVISIONAL DIAGNOSIS

S L dysfunction 8-05

DOCTOR'S SIGNATURE
K. L. Laybourn, MD
FCC Petersburg, Virginia
KLL

APPROVED

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

No sig -
- no pain when sig
- at
Rx - pm

sig - sig mmmfuul ↑
S-C space

(Continue on reverse side)

SIGNATURE AND TITLE 8/17 DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade) | REGISTER NO. | WARD NO.

Hill, Kenny
17110-016

cancel
K. L. Laybourn, MD
FCC Petersburg, Virginia

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

Health Services Unit
FCC Petersburg, Virginia

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Orthopedics | FROM: (Requesting physician or activity) Jens A Klepp MD | DATE OF REQUEST 3/10/05

REASON FOR REQUEST (Complaints and findings)

Doctor please evaluate this 42 y/o BM with hx of injury right wrist, c/o x-ray shows dislocation scapholunate joint, possible ligament avulsion. Thank you

PROVISIONAL DIAGNOSIS

Rule out scapholunate joint / ligament avulsion

DOCTOR'S SIGNATURE | APPROVED | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ TODAY ☐ ~~72 HOURS~~ ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

(R) wrist MRA b/l wrist injury 2 mo ago. on more burden. getting better

Cyp - Team over ulnar styloid.
No MRA findings. Watson OK

Dx - S-L dissociation
① Ulnar styloid contusion, resolving
② symptomatic S-L dissociation.

Rx - ① Ibuprofen first Dx virus B/L wrists
② F/U - 2 wks

Corrected 6/20/05

(Continue on reverse side)

SIGNATURE AND TITLE K. L. Laybourn, MD FCC Petersburg, Virginia | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade) | REGISTER NO. | WARD NO.

Hill, Kenny
17110-016

Health Services Unit
FCC Petersburg, Virginia

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Optometry	MEDICAL	11/19/09

REASON FOR REQUEST (Complaints and findings)

42 YM. BIM requesting Eye Dr re: blurred vision

PROVISIONAL DIAGNOSIS

OOR

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
JOSEPH M BAJARDO PHYSICIAN ASSISTANT	JBM	☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☑ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

PERIA APPD FROM FTFL CT Q-6

SLE OU
LL WNL
Conj inj
K 4
AC D+Q
X 4+
I.O WNL
Lens CL

NS Optometry 12/14/04
Late: Came in @ 1330 instead of 1000
VSC 20/20 — 20/20
OD PL
OS PL
ADD +1.50
.5 OD. 4
AV 2/3
MAC ⊕ FLR.
ONH health well perfused.

T < 16 < 17

PDGS
DFE ↓HT TMC 1355
OR 1/7/13

(A) emetrope Presbyope

(P) Reading ☒

(Continue on reverse side)

SIGNATURE AND TITLE: J. Mohrman OD 1622 DATE: 12/14/09

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR	SPONSOR'S NAME (Last, first, middle)	SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
HILL, Kenneth 17110-016 Health Services Unit-LOR FCC Petersburg, Virginia		

Opcon 4000 12/15/09

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

BILL TO: FCI PETERSBURG
PO#BOP040006[illegible]
106[illegible]VER RD
HOPEWELL
VA, 23860

OPT A 11

PATIENT NAME 17110-016 LI-9 111754
CUST. NUMBER PO: BOP040006-0
INVOICE NUMBER 210845
Tray No. 7842
Date Processed 02/04/2005 02/10/200

	Sphere	Cylinder	Axis	Prism	Base Curve
R. EYE	1.50				6.0
L. EYE	1.50				

	Add	Width	Height			N.P.D.
R. EYE		0.0	0.0	R. EYE	65.0	
L. EYE				L. EYE	65.0	

FRAME DATA

Size 48.0 Depth 40.0 E.D. 48.0 D.B.L. 22.0
Model: 73-74 0320271666[illegible] MPL. Length 50 48X22 SMOKE

EDGED UNCUT X LENS ONLY ENCLOSED TO COME SUPPLIED X

LENS DATA

	Type	Material
R:	SV CR-39 SRC1	SOLA 76
L:	SV CR-39 SRC1	SOLA 76

FDA CODE SEC. 3, 84, 21 CFR

THESE LENSES ARE IMPACT RESISTANT AND IN COMPLIANCE WITH FDA TESTING PRESCRIBED IN SEC. 3, 84, 21 CFR IMPACT RESISTANT LENSES ARE NOT UNBREAKABLE OR SHATTERPROOF.

NOTE FOLLOWING EXCEPTIONS

(1) PLASTIC: Mfr. certifies lenses ground to specifications are impact resistant within FDA code.
(2) UNCUT GLASS lenses have not been treated or tested and must be made impact resistant before dispensing.
(3) RAISED LEDGE multifocals have been made impact resistant, but are exempted from drop ball testing.

CHARGES

DESCRIPTION	PRICE
RIGHT LENS	11.00
LEFT LENS	11.00
73-74	12.00
SAFETY	.00
Sub Total	34.[illegible]
Freight	
Total Due	34.[illegible]

COMMENTS:
J-10250894 LI-9 T-7842
17110-016

OPT A 20

FROM: 111754
POSTMASTER
0845 IF THIS PACKAGE IS NOT DELIVERED IN FIVE DAYS, PLEASE RETURN TO SENDER

SHIP TO:
FCI PETERSBURG, BUS. OFF.
PO#BOP040006025S-S
1060 RIVER RD
HOPEWELL, VA, 23860 LOW
17110-016

AUDIOMETRIC EXAMINATION

Federal Prison System
U. S. Penitentiary
Terre Haute, IN 47808

PRIOR HEARING TEST (Year) FOR WHOM & CITY

1. Head Injury with unconsciousness
2. Head Noises or Ringing in Ears?
3. Dizziness?
4. Ear Drainage?
5. Earaches?
6. Measles?
7. Perforated Ear Drum?
8. Have you seen an Ear Doctor?
9. Ever use Firearms?
10. Rock Music - A Band Member?
11. Armed Service Branch
12. Motorcycles?
13. Tractor Hvy Equipment?
14. Snowmobiles?
15. Chain Saws, etc.
16. Hearing Loss in Family before age 50?

Name Hill, Kenneth
Date of Birth 7-17-62
No. 17110-016
Date Hired
Job Title
Department

COMMENTS:

EMPLOYEES EST. OF OWN HEARING: ☒ Good ☐ Fair ☐ Poor

AUDIOGRAMS

BASELINE ☐ PRE-EMPLOYMENT ☐ RECHECK ☐ REGULAR ☐

Date of Audiogram	Day of Week	Test Time	Ear Protection	JOB NOISE LEVEL DBA	HRS PER DAY
9-1-00	Fri	1436		STEADY NOISE Continuous ☐ Intermittent ☐ IMPULSE NOISE Continuous ☐ Intermittent ☐	

TIME SINCE ON JOB HOURS, EXPOSED TO LOUD NOISE SINCE JOB? YES ☐ NO ☐

ANSI 1969	RIGHT EAR 500	1000	2000	3000	4000	6000	8000	LEFT EAR 500	1000	2000	3000	4000	6000	8000
FREQ.														
THRESH-OLD	25	25	20	15	20	15	15	25	25	15	10	5	5	5

AUD
BY EXAMINER J. Williams, PA-C / R. Hazelwood, M.D. Staff Physician

AVERAGE HEARING LEVEL

R 500 1000 2000	R 3000 4000 6000 8000	L 500 1000 2000	L 3000 4000 6000 8000
23	18	22	10

COMMENT

BASELINE ☐ PRE-EMPLOYMENT ☐ RECHECK ☐ REGULAR ☐

Date of Audiogram	Day of Week	Test Time	Ear Protection	JOB NOISE LEVEL DBA	HRS PER DAY
2-1-01	Thurs	1110		STEADY NOISE Continuous ☐ Intermittent ☐ IMPULSE NOISE Continuous ☐ Intermittent ☐	

TIME SINCE ON JOB HOURS, EXPOSED TO LOUD NOISE SINCE JOB? YES ☐ NO ☐

ANSI 1969	RIGHT EAR 500	1000	2000	3000	4000	6000	8000	LEFT EAR 500	1000	2000	3000	4000	6000	8000
FREQ.														
THRESH-OLD	20	20	10	5	15	10	5	20	20	10	5	5	5	5

AUD
BY EXAMINER J. Williams, PA-C

AVERAGE HEARING LEVEL

R 500 1000 2000	R 3000 4000 6000 8000	L 500 1000 2000	L 3000 4000 6000 8000
17	10	17	7

COMMENT OK

BASELINE ☐ PRE-EMPLOYMENT ☐ RECHECK ☐ REGULAR ☐

Date of Audiogram	Day of Week	Test Time	Ear Protection	JOB NOISE LEVEL DBA	HRS PER DAY
				STEADY NOISE Continuous ☐ Intermittent ☐ IMPULSE NOISE Continuous ☐ Intermittent ☐	

TIME SINCE ON JOB HOURS, EXPOSED TO LOUD NOISE SINCE JOB? YES ☐ NO ☐

SI 1969	RIGHT EAR 500	1000	2000	3000	4000	6000	8000	LEFT EAR 500	1000	2000	3000	4000	6000	8000
REQ.														
HRESH-OLD														

AUD
BY EXAMINER

AVERAGE HEARING LEVEL

R 500 1000 2000	R 3000 4000 6000 8000	L 500 1000 2000	L 3000 4000 6000 8000

COMMENT

ASELINE ☐ PRE-EMPLOYMENT ☐ RECHECK ☐ REGULAR ☐

ate of Audiogram	Day of Week	Test Time	Ear Protection	JOB NOISE LEVEL DBA	HRS PER DAY
				STEADY NOISE Continuous ☐ Intermittent ☐ IMPULSE NOISE Continuous ☐ Intermittent ☐	

TIME SINCE ON JOB HOURS, EXPOSED TO LOUD NOISE SINCE JOB? YES ☐ NO ☐

I 1969	RIGHT EAR 500	1000	2000	3000	4000	6000	8000	LEFT EAR 500	1000	2000	3000	4000	6000	8000
EQ.														
RESH-LD														

AUD
BY EXAMINER

AVERAGE HEARING LEVEL

R 500 1000 2000	R 3000 4000 6000 8000	L 500 1000 2000	L 3000 4000 6000 8000

COMMENT

AUDIOGRAMS

ASELINE ☐ PRE-EMPLOYMENT ☐ RECHECK ☐ REGULAR ☐

ate of Audiogram	Day of Week	Test Time	Ear Protection

JOB NOISE LEVEL DBA
STEADY NOISE: Continuous ☐ Intermittent ☐
IMPULSE NOISE: Continuous ☐ Intermittent ☐
HRS PER DAY

TIME SINCE ON JOB HOURS, EXPOSED TO LOUD NOISE SINCE JOB? YES ☐ NO ☐

1969	RIGHT EAR							LEFT EAR							AUD	AVERAGE HEARING LEVEL R		AVERAGE HEARING LEVEL L	
EQ.	500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000	BY EXAMINER	500 1000 2000	2000 3000 4000	500 1000 2000	2000 3000 4000
RESH-OLD																			

COMMENT

SELINE ☐ PRE-EMPLOYMENT ☐ RECHECK ☐ REGULAR ☐

te of Audiogram	Day of Week	Test Time	Ear Protection

JOB NOISE LEVEL DBA
STEADY NOISE: Continuous ☐ Intermittent ☐
IMPULSE NOISE: Continuous ☐ Intermittent ☐
HRS PER DAY

IME SINCE ON JOB HOURS, EXPOSED TO LOUD NOISE SINCE JOB? YES ☐ NO ☐

1969	RIGHT EAR							LEFT EAR							AUD	AVERAGE HEARING LEVEL R		AVERAGE HEARING LEVEL L	
EQ.	500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000	BY EXAMINER	500 1000 2000	2000 3000 4000	500 1000 2000	2000 3000 4000
RESH-OLD																			

OMMENT

ELINE ☐ PRE-EMPLOYMENT ☐ RECHECK ☐ REGULAR ☐

e of Audiogram	Day of Week	Test Time	Ear Protection

JOB NOISE LEVEL DBA
STEADY NOISE: Continuous ☐ Intermittent ☐
IMPULSE NOISE: Continuous ☐ Intermittent ☐
HRS PER DAY

ME SINCE ON JOB HOURS, EXPOSED TO LOUD NOISE SINCE JOB? YES ☐ NO ☐

1969	RIGHT EAR							LEFT EAR							AUD	AVERAGE HEARING LEVEL R		AVERAGE HEARING LEVEL L	
EQ.	500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000	BY EXAMINER	500 1000 2000	2000 3000 4000	500 1000 2000	2000 3000 4000
IESH-.D																			

OMMENT

ELINE ☐ PRE-EMPLOYMENT ☐ RECHECK ☐ REGULAR ☐

e of Audiogram	Day of Week	Test Time	Ear Protection

JOB NOISE LEVEL DBA
STEADY NOISE: Continuous ☐ Intermittent ☐
IMPULSE NOISE: Continuous ☐ Intermittent ☐
HRS PER DAY

ME SINCE ON JOB HOURS, EXPOSED TO LOUD NOISE SINCE JOB? YES ☐ NO ☐

1969	RIGHT EAR							LEFT EAR							AUD	AVERAGE HEARING LEVEL R		AVERAGE HEARING LEVEL L	
EQ.	500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000	BY EXAMINER	500 1000 2000	2000 3000 4000	500 1000 2000	2000 3000 4000
ESH-D																			

OMMENT

marks:

MEDICAL RECORD | **REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES**

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Biopsy Lesion - Hair

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

Skin Biopsy, 4 mm R lower chest

which is to be performed by or under the direction of Dr. FREIHOFER

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: O

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

Erich J Freihofer MD
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

Kenneth E Hill — 11-16-05
(Signature of Patient) (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

Hill, Kenneth
17110-016

REGISTER NO. | WARD NO.

HEALTH SERVICES UNIT-LOW
FCC PETERSBURG, VA

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FPMR 101-11.806-8
522-109

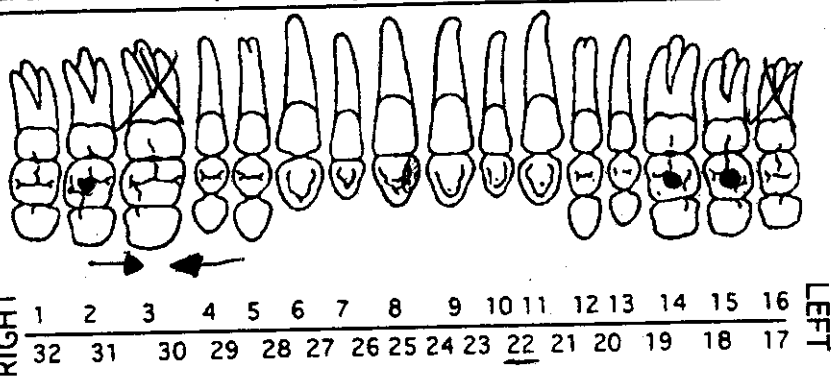
* U.S. GOVERNMENT PRINTING OFFICE : 1981 O - 341-526 (6423)

NSN 7540-00-634-4165

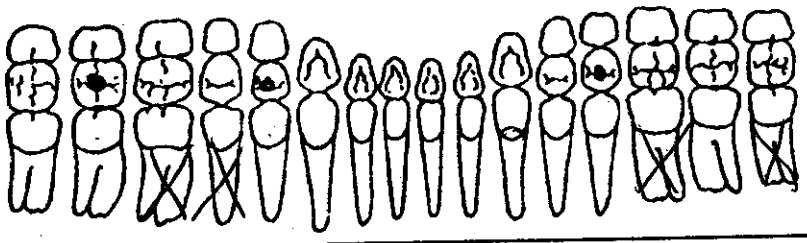
BP-S618.060 **CLINICAL DENT... RECORD** CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

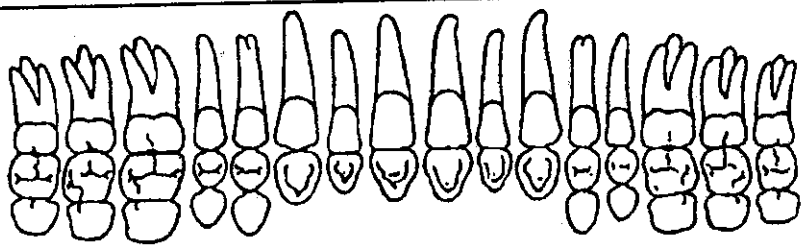
Examination: ☑ Screening ☐ Comprehensive ☐ Periodic



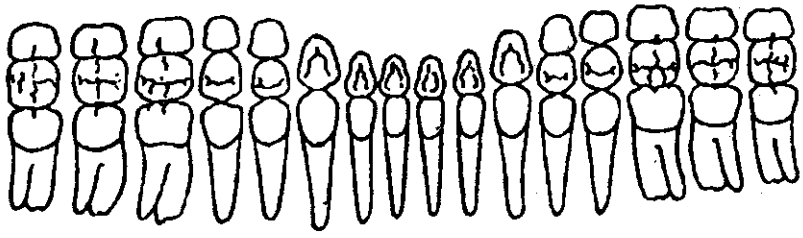
RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17



Treatment Completed



RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17



Patient Name Number Sex: M F Age:

Occlusion Cl I Ant Crowding

Oral Hygiene Good (Fair) Poor

CPITN 3 | 4 | 3
3 | 3 | 4

Head & Neck/Soft Tissue WNL

Additional Findings

D: 1
M: 6
F: 7

upper Ant. Crowding

Recommended Treatment Plan

☑ Radiographs

☑ Dental Prophylaxis
☑ Oral Hygiene Instruction

☐ Periodontal Evaluation 0 I II III

☐ Oral Surgical Procedures

☐ Endodontic

☐ Restorative

☐ Prosthodontic Evaluation

Dentist Signature Date

Aaron J Stobbe 7/12/06
Aaron J Stobbe Jr COSTEP

J. Vidrine, D.D.S
Chief Dental Officer

HILL,KENNETH 17110-016

USP TERRE HAUTE, IN

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
7/12/00 1030		Rev med. hx. Screening Exam. Hard & Sft tissue orally clinically CPITN. OHE on receiving care. Pt understands. [illegible] from J Stobbe Jr COSTEP
		J. Vidrine, D.D.S. Chief Dental Officer

Bureau of Prisons
Medical - Dental History

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS

1. Are you currently taking any medication? Yes___ No ✓
   If so, which?_____
2. Are you allergic to any medications? Yes___ No ✓
   If so, which?_____
3. Have you seen a doctor for any reason in the past two years? Yes___ No ✓
   If so, why?_____
4. Have you been hospitalized in the past 5 years? Yes___ No ✓
   If so, why?
5. Do you have chest pain, difficulty breathing, or do you feel exhausted when you walk or climb stairs? Yes___ No ✓
6. Do your feet or ankles swell during the day? Yes___ No ✓
7. Do you bleed excessively? Yes___ No ✓
8. Please check ( ) any of the following conditions you have now, or had:

___Congenital Heart Defects	___Bronchitis
___Heart Attack	___Emphysema
___Heart Murmur	___Tuberculosis
___Artificial Heart Valve	___Anemia
___Pacemaker	___Hepatitis
___High Blood Pressure	___Aids or HIV Positive
___Angina	___Venereal Disease (Syphillis, etc)
___Rheumatic Fever	___Arthritis
___Stroke	✓Headaches/Migraine
___Convulsions/Epilepsy	___Thyroid Problems
___Asthma	___Psychiatric Disorders
___Diabetes	___Artificial Joints
___Anxiety, Depression	___Cancer
___Injury to the Face or Jaws	___Liver, Kidney or Lung Problems

9. Do you have any other medical condition not mentioned here? Yes___ No ✓
   If so, which?_____
10. Have you had any difficulties or complications during previous dental treatment? Yes___ No ✓
    If so, what?_____
11. Do you have pain in you teeth or gums? Yes___ No ✓
12. Do your gums ever bleed? Yes ✓ No___
13. Do you have dental caries (cavities)? Yes ✓ No___
14. Do you have periodontal (Gum) disease? Yes___ No ✓

Name KENNETH E HILL Age 37 Registration Number 17110-016

U.S. PENITENTIARY
TERRE HAUTE, INDIANA 47808

Institution_____ Date 7-12-00

Patient's Signature Kenneth E Hill Dentist's Signature

John J Stitle Jr COSTEP

J. Vidrine, D.D.S.

Bureau of Prisons

Historial Medico - Dental

FAVOR DE CONTESTAR SI O NO A LAS SIGUIENTES PREGUNTAS

1. Esta tomando algun medicamento actualmente? Si___No___
   Cual o cuales?_____
2. Es alergico a algun medicamento? (Penicilina, Aspirin, etc) Si___No___
   A cual o cuales?_____
3. Ha estado bajo el cuidado de un medico por alguna enfermedad en los ultimos dos años? Si___No___
   Por Que?_____
4. Ha sido hospitalizado en los ultimos 5 años? S___No___
   Por que?_____
5. Tiene alguna dificultad para respirar dolor de pecho, o se siente agotado cuando camina o cuando sube escaleras? Si___No___
6. Se le hinchan los pies o tobillos durante el dia? Si___No___
7. Sangra usted en exceso? Si___No___
8. Indique si tiene o Ha tenido algunas de las signuientes condiciones:

___Defectos Congenitos Del Corazon
___Ataque de Corazon (Infarto)
___Soplo Cardiaco
___Valvulas Artificiales del Corazon
___Marcapasos,
___Presion Alta
___Angina de Pecho
___Fiebre Reumatica
___Apoplegia O Derrame Cerberal
___Convulsiones/Epiles PSIA
___Asma O Fatiga
___Diabetes
___Ansiedad Depresion
___Heridas A La Cara O Quijadas
___Bronquitis
___Enfisema
___Tuberculosis
___Anemia (Problems de Sangre)
___Hepatitis
___Sida O Infeccion de VIH
___Enfermedades Venereas (Sifillis)
___Artritis
___Dolores de Cabeza/Migraña
___Problemas de Tiroide
___Desordenes Psiquiatricos
___Coyunturas Artificiales
___Cancer
___Problemas de Higado, Rinon,

9. Tiene alguna otra condicion medica no mencionada aqui? Si___No___
10. Ha tienido alguna dificultad O complicacion durante tratamiento dental previo? Si___No___
    Cual?_____
11. Tiene dolor de dientes O encias? Si___No___
12. Le sangran las encias? Si___No___
13. Tiene caries O picaduras en los dientes? Si___No___
14. Tiene enfermentdad de las encias? Si___No___

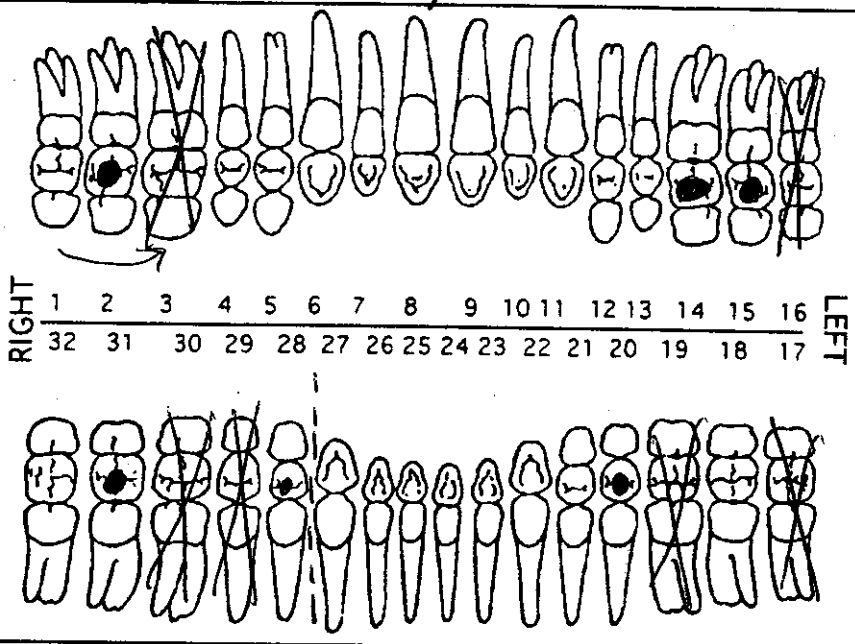
Nombre_____Edad___Numero de Registro_____

Institucion_____Fecha_____

Firma de Paciente_____Firma de Dentista_____

BP-S618.060 **CLINICAL DENTAL RECORD** CDFRM
AUG 96
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Examination: ☐ Screening ☑ Comprehensive ☐ Periodic



Occlusion: malocclusion

Oral Hygiene: Good Fair (Poor)

CPITN: 4 | 4 | 4 / 4 | 4 | 4

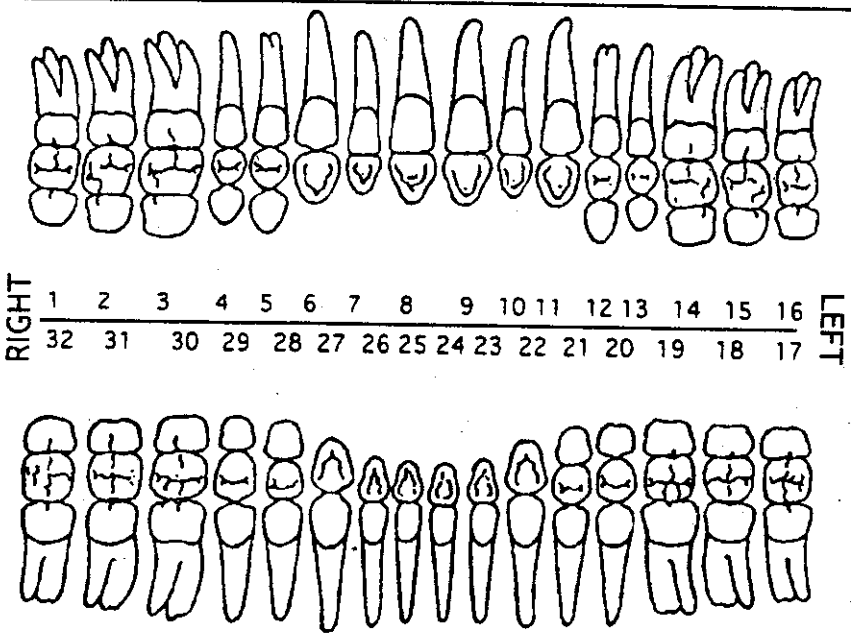
Head & Neck/Soft Tissue: STWNL
Mole located 3cm under (R) ear

Additional Findings

D: 0
M: 6
F: 6

↑+↓ Ant crowding
#7 + #10 crossbite

Treatment Completed



Recommended Treatment Plan

☑ Radiographs 07/23/02
☑ Dental Prophylaxis
☑ Oral Hygiene Instruction
☑ Periodontal Evaluation 0 I (II) III
☐ Oral Surgical Procedures
☐ Endodontic
☐ Restorative
☐ Prosthodontic Evaluation

Patient Name: Hill, Kenny
Number: 17110-016
Sex: (M) F
Age: 40
DOB: 7/17/62

Dentist Signature: William F. Collins DDS
Date: 6-28-02
7-23-02

W.K. COLLINS, DDS
CDO
FCI McKean

FCI McKean

PRINTED ON RECYCLED PAPER

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
6-28-02 0930hrs		SOA: Routine Care patient P: update medical history, Soft tissue exam, pt rinsed with 0.12% Chlorhex prior to scale - scale gross - hand & ultrasonic perio disease - heavy bleeding perio probe - reviewed floss technique severe inflamed gingival tissue generalized. teeth mal posed. Next: scale rt side - with anesthesia Jody L Batista Jody L Batista William K. Collins W.K. COLLINS, DDS CDO FCI McKean
7-23-02 0830hrs		SOA: Routine care patient P: update med hist, 4 bite wing radiographs - scaled rt. quadrants with anesthesia given by Dr Collins 5 carpules lidocaine 2% 1:100,000 epi Next: scale left side with anesthesia Jody L Batista Jody L Batista William K. Collins W.K. COLLINS, DDS CDO FCI McKean
8-28-02 0830hrs		SOA: Routine Care patient P: update medical history, scale with anesthesia left side - per Dr Collins 3 carpules 2% lidocaine with 1:100,000 epi pt rinsed with 0.12% Chlorhex prior to scale reviewed floss Jody L Batista Jody L Batista William K. Collins W.K. COLLINS, DDS CDO FCI McKean

FEDERAL BUREAU OF PRISONS
DENTAL/MEDICAL HEALTH HISTORY FORM

1. Are you currently taking any medication? If so, what?_____ yes (no)

2. Are you allergic to or have you had a reaction to any medication or drug? If so, what? _____ yes (no)

3. Have you been under the care of a physician during the past two years? If so, why? _____ yes (no)

4. Have you been hospitalized in the past two years? If so, why? _____ yes (no)

5. Do you have or have you ever had a heart murmur or been treated for a heart condition? yes (no)

6. Do your ankles ever swell during the day? yes (no)

7. Have you ever been treated for a tumor or growth? yes (no)

8. Have you ever had abnormal bleeding? yes (no)

9. Have you ever had serious difficulty with any dental treatment? yes (no)

10. Have you ever had clicking, popping, or pain in your jaw joint? yes (no)

Circle any of the following that you have had:

Congenital heart defects
Heart attack or heart problems
Stroke
Rheumatic Fever
Asthma
Anemia (blood problems)
Thyroid problems
Chronic bronchitis
Venereal disease (syphilis, gonorrhea)
Arthritis
Artificial heart valve
Hepatitis

Heart murmur
Angina
High Blood pressure
Heart pacemaker
Epilepsy or seizures
Diabetes
AIDS or HIV infection
Emphysema
Tuberculosis (TB)
Psychiatric treatment
Artificial joint

Do you currently use tobacco (cigarettes, chewing tobacco, snuff)? yes (no)

Do you have any disease, condition, or problem not listed?
WOMEN ONLY: Are you pregnant?

Name Kenny Hill Kenneth Hill Reg No. #17110-016

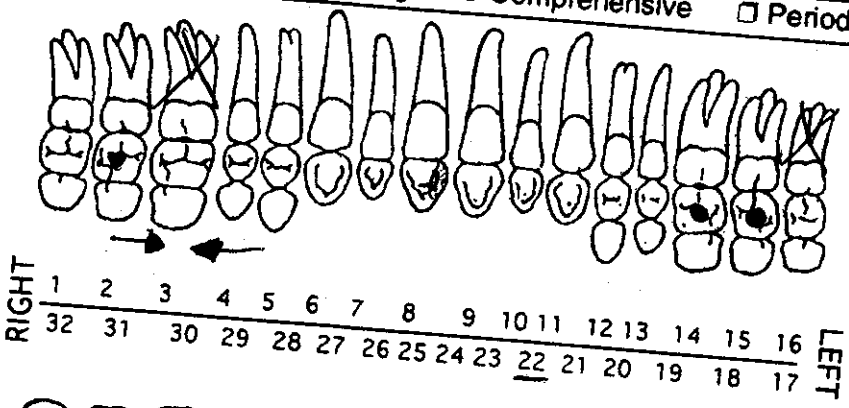
Institution: FCI McKean Date: 6-28-02

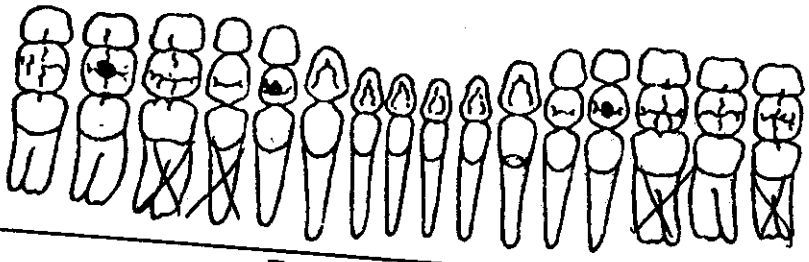
BP-S618.060 CLINICAL DENTAL RECORD CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE

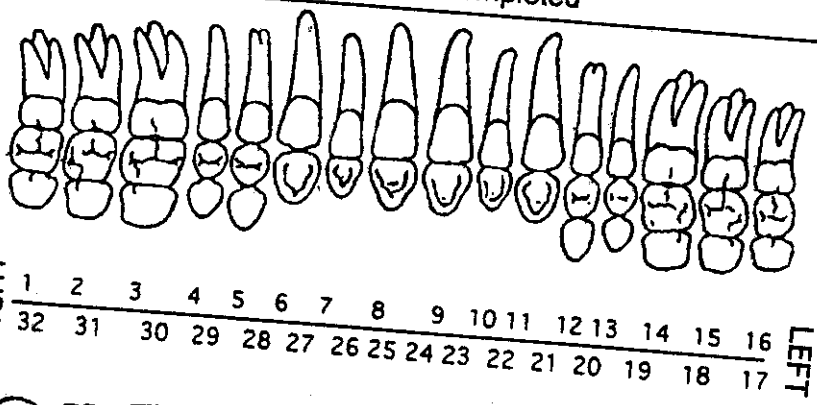
FEDERAL BUREAU OF PRISONS

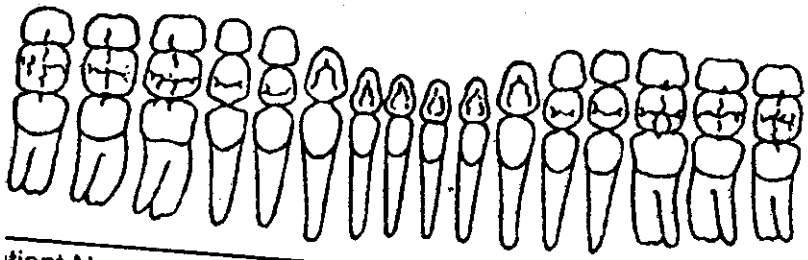
Examination: ☑ Screening ☐ Comprehensive ☐ Periodic





Treatment Completed





Occlusion: Cl I Ant Crowding

Oral Hygiene: Good (Fair) Poor

CPITN: 3 | 4 | 3 / 3 | 3 | 4

Head & Neck/Soft Tissue: WNL

Additional Findings

D: 1
M: 6
F: 7

upper Ant. Crowding

Recommended Treatment Plan

- ☑ Radiographs
- ☑ Dental Prophylaxis
- ☑ Oral Hygiene Instruction
- ☐ Periodontal Evaluation 0 I II III
- ☐ Oral Surgical Procedures
- ☐ Endodontic
- ☐ Restorative
- ☐ Prosthodontic Evaluation

itient Name Number Sex: M F Age:

HILL,KENNETH 17110-016

Dentist Signature Date

Aaron J Stobbe 7/12/00

Aaron J Stobbe Jr COSTEP

J. Widing DDS

IRE HAU...

Bureau of Prisons

Historial Medico - Dental

FAVOR DE CONTESTAR SI O NO A LAS SIGUIENTES PREGUNTAS

Esta tomando algun medicamento actualmente? Si___No___
Cual o cuales?_____

Es alergico a algun medicamento? (Penicilina, Aspirin, etc) Si___No___
A cual o cuales?_____

Ha estado bajo el cuidado de un medico por alguna enfermedad en los ultimos dos años? Si___No___
Por Que?_____

Ha sido hospitalizado en los ultimos 5 años? S___No___
Por que?_____

Tiene alguna dificultad para respirar dolor de pecho, o se siente agotado cuando camina o cuando sube escaleras? Si___No___

Se le hinchan los pies o tobillos durante el dia? Si___No___

Sangra usted en exceso? Si___No___

Indique si tiene o Ha tenido algunas de las signuientes condiciones:

___Defectos Congenitos Del Corazon
___Ataque de Corazon (Infarto)
___Soplo Cardiaco
___Valvulas Artificiales del Corazon
___Marcapasos
___Presion Alta
___Angina de Pecho
___Fiebre Reumatica
___Apoplegia O Derrame Cerberal
___Convulsiones/Epiles PSIA
___Asma O Fatiga
___Diabetes
___Ansiedad Depresion
___Heridas A La Cara O Quijadas
___Bronquitis
___Enfisema
___Tuberculosis
___Anemia (Problems de Sangre)
___Hepatitis
___Sida O Infeccion de VIH
___Enfermedades Venereas (Sifillis)
___Artritis
___Dolores de Cabeza/Migraña
___Problemas de Tiroide
___Desordenes Psiquiatricos
___Coyunturas Artificiales
___Cancer
___Problemas de Higado, Rinon,

Tiene alguna otra condicion medica no mencionada aqui? Si___No___

Ha tienido alguna dificultad O complicacion durante tratamiento dental previo? Si___No___
Cual?_____

Tiene dolor de dientes O encias? Si___No___

Le sangran las encias? Si___No___

Tiene caries O picaduras en los dientes? Si___No___

Tiene enfermentdad de las encias? Si___No___

Nombre_____Edad____Numero de Registro_____

Institucion_____Fecha_____

Firma de Paciente_____Firma de Dentista_____

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE IN... ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCC Pet. Low, VA	Hill, Kenny	17110-016
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
Orderly at Carolina	Carolina 15 upper	2/10/05 12:00
7. Where Did Injury Happen (*Be specific as to location*)	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
Medical Low (Door)		2/10/05 12:20

9. Subjective: (*Injured's Statement as to How Injury Occurred/Symptoms as Reported by Patient*)

I was bringing the WHEELCHAIR THROUGH THE FRONT DOOR OF THE HOSPITAL. DOOR SLAM ON MY WRIST.

Kenny E. Hill
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

BP 126/70, 75, Temp 99.0 — *X-Rays ~~Taken~~* ☒ **X-Ray Results** Pending Negative — *Not Indicated* ____

Red, Swollen to (R) Wrist. Discomfort with motion, pulses present No Cuts or Bones Noted.

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

(1) Discomfort to touch (2) ↓ movement to extremely with discomfort.

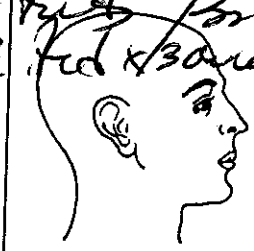
12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

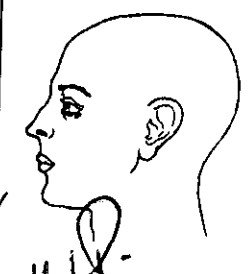
(1) X-ray of (R) Wrist ordered by PA Negron/Low 2/10/05
(2) Motrin 200mg po tid D/C med one
(3) Pt educated about CARE of R/L wrist edema

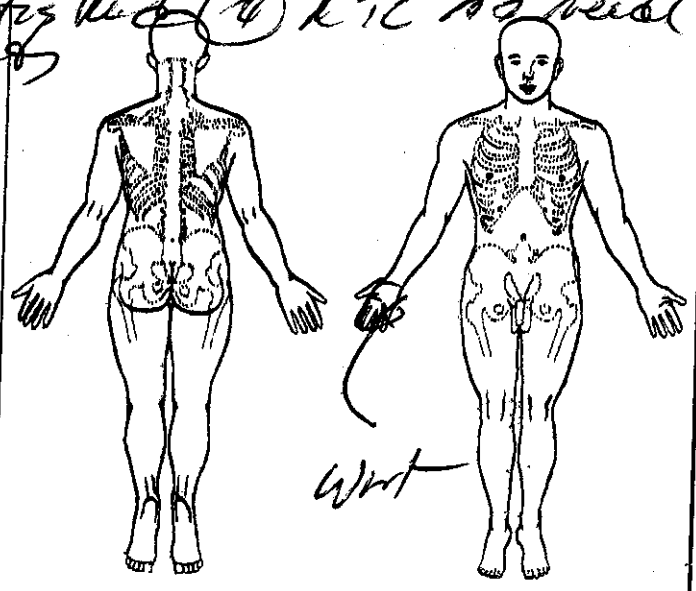
13. This Injury Required:

- ☐ a. No Medical Attention
- ☒ b. Minor First Aid
- ☐ c. Hospitalization
- ☐ d. Other (*explain*) Category II
- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

ICE Ice/Tylenol/Motrin D/C to med







Signature of Physician or Physician Assistant

Self Carboned Form – If ballpoint pen is used, **PRESS HARD**

Original – Medical File
Canary – Safety
Pink – Work Supervisor (*Work related only*)
Goldenrod – Correctional Supervisor

USP LVN

BP-362(60)

FEDE L CORRECTIONAL INSTITUTION H( )ITAL
FCI Petersburg, Petersburg, VA 23804

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

: ALL CONCERNED
MATE'S NAME: Hill, Kenneth UNIT Carolina DETAIL Orderly
REG. NO.: 17110-016

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

EDICAL CLASSIFICATION STATUS: (Check One and answer questions)

( ) IDLE: Reason O/C Dent 5/17/05 THRU 12 MIDNIGHT 5/17/05, 20____

( ) CONVALESCENT: List any restricted activity for medical reasons. _____

_____ THRU 12 MIDNIGHT _____, 20____

(X) RESTRICTED DUTY: Specify exact restriction and reason. ND Rec.

_____ THRU 12 MIDNIGHT _____, 20____

( ) MEDICAL UNASSIGNED:

( ) BED REST:

L. Khan, DDS
FCC Petersburg, Virginia
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

.E STATUS - Temporary disability not to exceed three days duration including weekends and holidays. Restricted to quarters except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.

)NVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. No work and no sports.

.STRICTED DUTY - Restricted from work around machinery, heights, heavy lifting, etc., because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefinite.

:DICAL UNASSIGNED: - Totally unemployable and unassigned because of mental or physical reasons.

White copy - File Yellow copy - Medical Records Pink copy - Detail Supervisor Gold copy - Unit

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member) CR. Abramowicz	DATE: 2-6-05
	REGISTER NO.: # 17110-016
FROM: Mr. Kenny E. Hill	UNIT: Carolina Hall
WORK ASSIGNMENT: Carolina Ord.	

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would Like To Know If I Could Pick Up My Glasses I Really Need Them Bad! Thank you Very Much

Please Take This Into Consideration.

(Do not write below this line)

DISPOSITION:

Copy attached

Signature Staff Member	Date
F. Wilson	3/1/05

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title ~~of Staff Member~~) Dental	DATE: 11-30-04
FROM: Henry E. Hall	REGISTER NO.: ~~#~~ 17110-016
WORK ASSIGNMENT: EDU. ORD.	UNIT: CAROLINA HALL

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like to have my teeth pulled H.S.A.P.

P.S. I was talking to you last week about my X-RAYS of my teeth.

Thank you very much

(Do not write below this line)

DISPOSITION:

Sign up on sick call

Signature Staff Member K. Oliver, Dental Assistant | Date 12/8/04

Record Copy - File; Copy - Inmate
(This form may be replicated via WP) This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Health Services Unit-Low
FCC Petersburg, Virginia

BP-S148.055 **INMATE REQU. T TO STAFF** CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and ~~Title~~ of Staff Member) DENTIST	DATE: 12-28-04
FROM: MR. LEWIS E. HALL	REGISTER NO.: 17110-016
WORK ASSIGNMENT: EDUC. ORD.	UNIT: CAROLINA HALL

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like to have my tooth pulled. A.S.A.P. If I can't do have me X-rayed.

P.S. I talked with you 2-weeks ago and you put me on out list.

(Do not write below this line)

DISPOSITION:

Please sign up a sick call for your tooth taken out

Signature Staff Member: L. Wan MD

Date: 12/28/04

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

Correctional Supervisor

FROM: Mr. Lenny Hall	REGIST NO.: 17110-016
WORK ASSIGNMENT: Unicor II	UNIT: BA-208-21

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action be taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like you to send me this (one) copy of my medical records ASAP.

Thank You
Lenny Hall

(Do not write below this line)

DISPOSITION:

See Attached (4)

FCI McKean

Signature Staff Member T. Kelly

Date 9-12-03

Record Copy - File; Copy - Inmate
This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

U.S. DEPARTMENT OF JUSTICE — FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) Dentist	DATE: 4-17-03
FROM: M. Lenny Hill	REGISTER NO. 12110-016
WORK ASSIGNMENT: Unicor II	UNIT: 3A-208-U

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like to have my teeth clean.

Thank You
Very Much,

(Do not write below this line)

DISPOSITION:

Your name has been added to the dental waiting list. Please watch the call-outs.

Thank-You

Signature Staff Member	Date
J. Colvin DA	4/18/03

White Copy - Record Copy - Pink Copy - Inmate
This form may be replicated via WP

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) Hospital-Sick Call	DATE: 4-17-03
FROM: Mr. Leroy Hill	REGISTER NO. 17110-016
WORK ASSIGNMENT: Unicor-II	UNIT: 8A-208-U

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like a copy of my FTCA and Medical files.

Thank You
Leroy Hill

(Do not write below this line)

DISPOSITION:

See Attached
2 Pgs.

FCI McKean

Signature Staff Member

Date 4/21/03

Record Copy - File; Copy - Inmate
This form may be replicated via WP

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and ~~Title~~ of Staff Member) Dentist	DATE: 1-8-03
FROM: M. Lenny Hill	REGISTER NO.: ~~44~~ 17110-016
WORK ASSIGNMENT: Unicor II	UNIT: SA-208-U

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like to have my teeth clean.

Thank you

M. Lenny Hill

(Do not write below this line)

DISPOSITION:

Your name has been added to the dental cleaning list. Please watch the call outs.

Signature Staff Member	Date
J Batista	1-21-03

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

FCI McKean

Inmate Sick Call Sign-Up Sheet

(Formulario y Registro para Atencion Medica de Confinados)

9/13/02
8:30a

INSTRUCTIONS:

You must fill out this form completely, numbers 1-9:
(Debe de llanar este formulario completamente, numeros 1-9.)

1. Name: (Nombre) Kenny Hill
2. Reg. Number: (Numero de Registro) 17140-016
3. Date: (Fecha) 9-3-02
4. Housing unit and Unit Team: (Unidad y equipo de la unidad) BA-244-L TEAM: A B C D
5. Complaint. What is your problem ? (Queja) (Cual es su problema?) I have a real bad RASH on my neck and arm. Also, my feet peel same as the toes.
6. How long have you had this problem? (Durante cuante tiempo ha tenido este problema?) Days_____ Months_____ Years 2
   Dias) (Meses) (Anos)
7. Are you on any medication(s) at present? Yes_____ No_____
   (Esta usted tomando alguna(s) medicinas actualmente?)
8. Have you purchased Over-the-Counter Medications from Commissary?
   (Ha comprado medicinas non-prescipcion en la Comisaria?
   Yes_____ No ✓
9. Signature (Firma) Kenny Hill

TO BE COMPLETED BY HEALTHCARE STAFF TRIAGE PERSONNEL:

10. Date Seen:_____
11. Time Seen:_____
12. Subjective:_____
13. Objective: Temp._____ Pulse_____ Respirations_____ B/P_____
13. Appointment Date: 9/13/02 Appointment Time 8:30a
14. Triage Personnel's Signature: H Nelson PA

BP-S148.055 **INMATE REQUE: O STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and ~~Title of Staff~~ Member) Dewist	DATE: 7-22-02
FROM: Mr. Kenny Hall	REGISTER NO.: #17110-016
WORK ASSIGNMENT: Unicor II	UNIT: BA-110-L

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like to have my teeth clean.

Thank you very much,

(Do not write below this line)

DISPOSITION:

Your name has been added to our waiting list. Please watch the call outs.

Signature Staff Member: Johnna Schuck

Date: 7-22-02

d Copy - File; Copy - Inmate
rm may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

ted on Recycled Paper

TO, P.H.
FROM; KENNETH HILL #17110-016
CELL; A-203

I WOULD LIKE IF
SOMEONE COULD TAKE A
LOOK AT MY BACK
AND FEET A.S.A.P.!!

I THANK YOU
VERY MUCH.

Come to Sickcall

H Beamm
4/11/02

H. BEAM, MD
FCI McKEAN

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member) Mr. William Collins	DATE: 11-13-01
FROM: Kenny Hill	REGISTER NO.: 17110-016
WORK ASSIGNMENT: Unicor PM.	UNIT: BA-235-L

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like to know if I could get my teeth cleaned. Also, how long am I on the dental list

Thank You

(Do not write below this line)

DISPOSITION:

You are #115 on the list. Please continue to watch the call-outs.

FCI McKean

Signature Staff Member	Date
A. Douglas CDA	12-19-01

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-S148.070 dated Oct 86 and BP-S148.070 APR 94

BP-S148.055 **INMATE REQUES. TO STAFF** CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member)	DATE: 5-29-01
FROM: M. Kenny Hill	REGISTER NO.: 17110-016
WORK ASSIGNMENT: ORD-BA	UNIT: BA-235-L

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like to take a full physical as soon as possible.

Thank you
Very Much

M. Kenny Hill
#17110-016
BA 235-L

(Do not write below this line)

DISPOSITION:

You had a physical exam on 7/12/00. You are authorized to have another one after 7/12/02.

FCI McKean

Signature Staff Member D. Olson, MD Clinical Director | Date

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and ~~Title of Staff~~ Member) DENTAL	DATE: 6-8-01
FROM: Kenny Hill	REGISTER NO.: 17110-016
WORK ASSIGNMENT: ORD - BA	UNIT: BA-235-L

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like to know if I could get my teeth looked at, its very important. Also, I need them cleaned.

Thank You
Kenny Hill

(Do not write below this line)

DISPOSITION:

Your name has been added to the waiting list. Please watch the call-outs.

FCI McKean

Signature Staff Member	Date
D. Tanner, HZ7 D. Tanner	HIT 6-8-01

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

FCI McKean

MEDICAL DUTY STATUS ASSIGNMENTS

ASSIGNMENT	DESCRIPTION
____ALLRG/WOOL	ALLERGIC TO WOOL
____ART LIMB	ARTIFICIAL ARM OR LEG
____ATH RESTR	SPORTS/NO WEIGHT LIFTING
____COLD/WIND	NO EXCESS COLD/WIND
____DRIV RESTR	GLASSES REQUIRED FOR DRIVING
____HEAR RESTR	NO WORK IN HIGH NOISE AREAS
____HGT RESTR	NO LADDERS/NO UPPER BUNK
____HUNGR STRK	HUNGER STRIKE
____LIMIT SUN	NO EXCESS SUN
____LOWER BUNK	LOWER BUNK REQUIRED
____NO DRIVING	NO DRIVING - MEDICAL CONDITION
____NO DUTY	NO DUTY DUE TO MEDICAL CONDITION
____NO F/S	NO FOOD SERVICE WORK
____NO POLLUT	ASSIGN TO POLLUTION FREE AREA
____NOT MED CL	NOT MEDICALLY CLEARED
____ORTH SHOES	ORTHOPEDIC SHOES
____OTHER	OTHER MEDICAL RESTRICTION
_✓_REG DUTY	REGULAR DUTY
____REG DUTY W	REGULAR DUTY W/MED RESTRICTION
____REPAT MEN	REPATRIATION MENTAL
____REPAT PHY	REPATRIATION PHYSICAL
____REPAT SUM	REPATRIATION SUMMARY REPORT
____SMOKE FREE	ASSIGN TO SMOKE FREE WORK/QTRS
____SOFT SHOES	SOFT SHOES REQUIRED
____SPEC DIET	SPECIAL DIET - MEDICAL CONDITION
____STAND RSTR	NO PROLONGED STANDING
____SUIC WATCH	SUICIDE WATCH
____WGT 15 LB	WEIGHT - NO LIFTING OVER 15 LBS
____WGT 20 LB	WEIGHT - NO LIFTING OVER 20 LBS
____WGT 25 LB	WEIGHT - NO LIFTING OVER 25 LBS
____WIRED JAW	WIRED JAW - POST DENTAL
_✓_YES F/S	CLEARED FOR FOOD SERVICE

NKDA ALLERGIES

CLINICS

____
____CARDIAC
____DIABETIC
____GENERAL
____HYPERTENSION
____INFECT. DISEASE
____MENTAL HEALTH
____NEUROLOGY
____PULMONARY
____

INMATE HILL,KENNETH 17110-016
INMATE
DATE: 07-12-00
REVIEWI

USP / FPC
TERRE HAUTE, IN 47808